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Award-Winning Journal of the Michigan State Medical Society

JULY 1989
VOL. 88, NO. 7

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Cover Story

Maintaining a healthy medical practice in the 1990s and beyond will require an increasing amount of a physicians time and energy. Expert advice and information on topics such as employee relations, financial management, third party relations, patient flow, scheduling, and strategic planning will be imperative. Because MSMS recognizes this fact, and already is providing expert physician services through its subsidiary — Physician Service Group, Inc. — practice management is the subject of this month's cover story. Included in the cover story is an examination of practice management trends; expert advice on practicing in the 1990s; an in-depth profile of Physician Service Group, Inc.; an explanation of the MSMS Group Insurance Trust; and a look at the benefits of having a practice management audit.

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Cover illustration by: *Robert L. Brent.*

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AXID®

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Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done Part of the dose of nizatidine is metabolized in the liver In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b i d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations) The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy – Teratogenic Effects – Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers — Studies conducted in lactating women have shown that <0 1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations Caution should be exercised when administering nizatidine to a nursing mother

Pediatric Use — Safety and effectiveness in children have not been established

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine Elderly patients may have reduced renal function

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0 2%), urticaria (0 5% vs < 0 01%), and somnolence (2 4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo Rare reports of gynecomastia occurred

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs Rare cases of thrombocytopenic purpura have been reported

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported

Overdosage: Overdoses of Axid have been reported rarely The following is provided to serve as a guide should such an overdose be encountered

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)* In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis for four to six hours increased plasma clearance

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Additional information available to the profession on request.

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IN MY OPINION

Physician Service Group Helps Physicians Tackle the Business Side of Medicine

By Elizabeth Hutchinson, MD

In 1984 I was asked to take part in the development of what, at the time, was a new subsidiary of MSMS — Physician Service Group, Inc. (PSG). I was told this new arm of the Society would concentrate on the development of an aspect of medicine with which I had very little experience: business. Looking forward to a new adventure in learning, I accepted the position. In the five years since, I have never been disappointed.

The inseparable nature of medicine and business has become a vivid reality, and the outstanding job PSG has done in bringing better business to many Michigan physicians is something of which I am proud to be a part.

The Physician Service Group has grown from what was initially a somewhat cautious group into a dynamic and aggressive proponent of good business in Michigan medicine. PSG certainly has lived up to its label as a service group, today providing programs in almost every imaginable aspect of medical/business practice. From group insurance plans to billing and collection services, the many successes of PSG are seen in medical practices around the state. Ancillary areas as well, are addressed by PSG through seminars on topics from retirement planning to stress in the medical family.

As board members and staff, we at PSG are committed to bringing MSMS members access to the best and most innovative services available.

As is so often the case, the success or failure of an organization or project is dependent upon the people who run it; PSG is no exception.

The success of PSG is a reflection of the quality of people who develop and administer its programs. The diversity of PSG's board of directors, whose membership represents many different medical specialties and many geographic areas of the state, has resulted in quality programs which address the business needs and concerns of every kind of physician. Their foresight and intuition has produced a series of programs which are destined to stand the test of time by continuing to make the practice of medicine efficient and reliable. The PSG staff and its general manager, John Richards, have ensured the success of PSG programs by demonstrating outstanding business savvy and an unerring ability to nurture vital relationships in the business world. With the active participation and support of MSMS membership, these people have helped make PSG an invaluable extension of MSMS.

By making the complex business of medicine a less formidable obstacle, PSG has helped to give physicians the freedom to practice better medicine. It has been exceptionally gratifying to see the people and programs of PSG help physicians enhance the possibilities of their medical practices.

I encourage all MSMS members and interested physicians to share with PSG ideas for new and better services which can make a practice stronger or, in other ways, enhance professional life. I also invite you to discover what PSG already has to offer your practices. I look forward to sharing these services with you through PSG.

Doctor Hutchinson is a Lansing dermatologist and is a member of the PSG Board of Directors.

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Letters from Our Readers

Readers respond to the "new" *Michigan Medicine*

Editor's note: MSMS Publications Committee Chairman Henry M. Domzalski, MD, recently polled MSMS leaders, spokesmen for other health care organizations, and other key persons on their reactions to the redesign of *Michigan Medicine*. Twenty-two persons have responded to date. A sampling of their comments follows.

"It is great! I love the design and style. Congratulations to you and your staff."

Robert E. Paxton, MD
MSMS President

"The new format for *Michigan Medicine* is beautiful! It's crisp and business-like — so professional. I thought the former style was pretty darned good, but this is simply great. You and the staff are to be congratulated on a job well done."

Brooker L. Masters, MD
Fremont

"Much progress — a cleaner look."

Robert D. Burton, MD
Speaker
MSMS House of Delegates

"Fresh look, easier to look through and pick things I want to read in depth."

B. David Wilson, MD
Chairman
MSMS Finance Committee

"Excellent — First-class magazine that is easy to read and attractive to look at."

Frederick W. Minkow, MD
Member of the MSMS Board

"I enjoy the new format. It makes the publication much more professional, readable, and there's a lot less wasted space. You, your committee and staff are to be commended. Congratulations!"

Cathy O. Blight, MD
Flint

"I like the changes in *Michigan Medicine* very much. We have had a redesign done on our journal and already have received praises from readers. All of which helps me to remember one factor in selling advertising space for us; that is, that we have all been in the business for years and years, and basically do it the same way all the time. I hope enough journals change design and obtain some boosts for our advertising income."

Frank B. Ramsey, MD
President and Chairman
State Medical Journal
Advertising Bureau
Chicago

"I like some of the artwork you've used. It gives a warmer, softer feel."

Kirk G. McMurray
Executive Director
DuPage County Medical Society
Illinois

"I enjoy the covers (artwork vs. four-color photographs), and find them a most pleasant change. I personally like photos better than artwork, but artwork allows for greater creativity in tying cover to feature focus of magazine. Use of interior color really lends interest and brightness."

Merwyn G. Scholten
Executive Director
West Virginia Medical Society

"Your new design is excellent. Congratulations to all. The changes have a fresh, clean look, and work well together."

Mary Uehlein
Managing Editor
Pennsylvania Medicine

"All the style changes seem to have increased 'reader friendliness' — a much more inviting magazine to read! Really like the design of the April issue and how you carried the artwork through the articles. 'Medical Newsfronts' looks great and reads well (lots of members' names — good!"

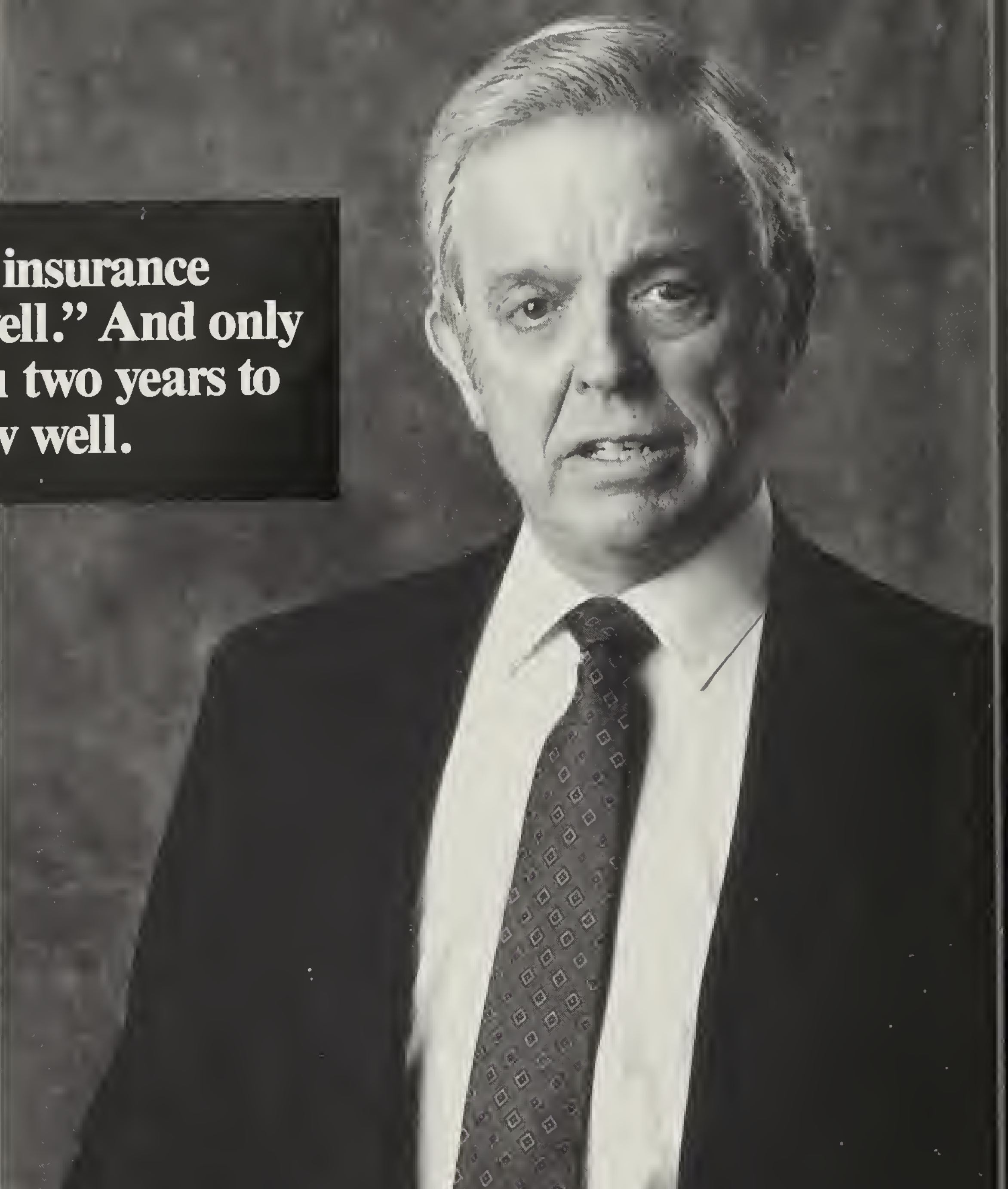
Tina Steger-Gratz
Managing Editor
Michigan Dental Association

"Cleaner layout, more information, sharper cover. The whole thing is more attractive and more likely to be read."

Peter Levine
Executive Director
Genessee County Medical Society

"I think the new look of *Michigan Medicine* is great. The visual look of *Michigan Medicine* I'm sure is going to attract a lot more attention and readership from our physicians."

John Richards
Manager
MSMS Subsidiary Operations



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MEDICAL NEWSFRONTS

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New umbrella filter captures life-threatening blood clots

An investigational device that utilizes NASA-developed technology "makes a procedure that was fraught with danger extremely simple," says Marc Kahn, MD, director of Interventional Radiology at Sinai Hospital, Detroit.

About a quarter-million Americans die each year from blood clots that have migrated from their legs to their lungs. Many of those who develop leg clots can be treated with blood thinning medication. But, for those who do not tolerate or respond to the thinners, the only available preventive treatment has been the surgical installation of a metallic device that traps the clots.

This method, currently used in most hospitals, takes about an hour and often requires general anesthetic and hospitalization. At Sinai, that procedure has been replaced with the Simon Nitinol Filter. Nitinol is a unique metal whose thermal memory permits it to retain one shape at room temperature and assume a pre-programmed form at body temperature.

Doctor Kahn makes a small incision about the diameter of an eraser in the groin or neck. He inserts a plastic sheath containing the slender, coiled nitinol wire, cooled by a saline solution, and he threads it to the abdomen's large vein. When the wire is in place, he extrudes the hollow tube. Instantaneously, the body's warmth causes the little "umbrella" skeleton to open.

The whole procedure takes about ten minutes. The patient is awake and comfortable. If not already hospitalized, the patient can go home. The filter remains in place permanently to capture and retain any life-threatening clots while permitting blood to flow unobstructed.

For more information on the procedure, call (313) 493-5500.

Kellogg grant to create community approach to elderly, child care

The Joint Commission on Accreditation of Healthcare Organizations has joined with Battle Creek Health System, Battle Creek, Michigan, and Kaiser Permanente Northwest Region, Portland, Oregon, to develop and test a comprehensive process for assessing health care quality, and to improve communitywide care for the elderly, children and adolescents.

The three-and-a-half-year project, entitled, "Strategies for Improving Quality of Health Care in Two Patient Communities," is supported by the W.K. Kellogg Foundation, Battle Creek. The $987,454 grant award will be shared equally by the three partners.

The Joint Commission will draw on its clinical indicator development experience, achieved through its "Agenda for Change" project, to help craft and test appropriate clinical outcome measures. It also will oversee development of health system guidelines and help the two communities conduct self-evaluations.

The communitywide assessment process will be used to monitor and improve the quality of elderly care provided in the Battle Creek metropolitan area, and the quality of preventive and therapeutic care provided to children and adolescents enrolled in the Kaiser Permanents Northwest Region HMO in Portland.

$7 million grant supports studies of stroke, dementia

Preliminary studies at Henry Ford Hospital suggest it be possible someday to condition the human brain to resist the ravages of stroke, according to K.M.A. Welch, MD, principal investigator for Henry Ford Hospital's Stroke Center and chairman of Neurology.

"We've found that if you subject the brain to a quick episode of transient ischemia (a small stroke), there will be less damage to the brain from more severe, subsequent attacks," Doctor Welch says. Researchers are studying this phenomenon to see if it can be used to develop a practical method for providing immunity against the disabilities normally associated with stroke by "preconditioning" the brains of high-risk individuals.

This research is among the dozens of ongoing studies into the causes, prevention and treatment of stroke supported by funding from the National Institutes of Health (NIH). The recent award of a $7 million, five-year grant from the NIH ensures that the Stroke Center's researchers will be able to continue their groundbreaking investigations.

As one of only 14 NIH-designated Stroke Centers in the country, the Center's research could ultimately benefit the more than 500,000 Americans who suffer from stroke each year as well as the many thousands who are at risk. Stroke is presently the nation's third leading cause of death. Among those who survive stroke, at least two-thirds suffer some degree of permanent disability.

Currently, the Center's research priorities include discovering more effective strategies for minimizing brain damage caused by stroke, developing more accurate tests for evaluating changes in the brain caused by stroke, and exploring the therapeutic value of keeping blood glucose levels low in stroke victims by using an artificial pancreas.

In addition to continuing their studies of stroke, researchers also will be looking at the causes of Alzheimer's disease and other dementing illnesses. Stroke Center researchers already have discovered that patients with Alzheimer's disease have characteristic abnormalities in their brain's metabolism. "We have been able to demonstrate that there are key markers of brain metabolic abnormalities which help distinguish Alzheimer's disease from other types of dementia," Doctor Welch says.

National MS Society names Riegle "Senator of the Year"

Senator Donald W. Riegle (D-Flint) has been named "Senator of the Year" by the

Continued on page 10

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National Multiple Sclerosis Society.

"Senator Riegle has established himself as a leader on Social Security and health issues affecting people with multiple sclerosis and all disabilities," said Thor Hanson, president and CEO of the Society.

Senator Riegle's legislative initiatives include the Social Security Work Incentive Act. This bill, according to Hanson, would "provide Social Security Disability Insurance beneficiaries with the most important work incentives Congress has provided in many years."

Senator Riegle is also the sponsor of the resolution designating the next 10 years as the "Decade of the Brain."

"By focusing attention on the brain, Senator Riegle will help the National Multiple Sclerosis Society — and other organizations that represent people with disorders of the brain and neurological system — promote the research necessary to finding the causes, cures and preventions," Hanson said.

With the Senator recently appointed chairman of the Finance Committee's Subcommittee on Health for Families and the Uninsured, Hanson said, "We can expect fresh ideas with the difficult and urgent national problems."

The "Senator of the Year" award was instituted by the National Multiple Sclerosis Society in 1984 to honor and provide recognition to members of the Senate whose consistent support for medical research and rehabilitation programs helps people with disabilities live more fulfilling lives.

Bronson receives $200,000 challenge grant from Kresge Foundation

The Bronson Health Foundation, a subsidiary of the Bronson Healthcare Group, has been awarded a $200,000 challenge grant by the Kresge Foundation. The funds will go toward the construction of a new Trauma and Emergency Center and expansion of the Outpatient Services Department at Bronson Methodist Hospital.

Construction of the facility began in September 1988, and is expected to be completed by early 1990. The new Trauma and Emergency Center will replace a 20-year-old, overburdened facility which cannot be expanded. The current center was built to accommodate 30,000 patients each year. In 1988, there were close to 43,000 emergency visits at Bronson.

The project also allows for expansion of the hospital's other outpatient services facilities whose patient visits also are dramatically increasing.

The Kresge grant was awarded on a challenge basis, requiring that Bronson raise approximately $500,000 by December 1990. This is the balance of funds needed to reach the campaign goal of $2 million. The capital campaign, which began in spring 1988, has so far raised $1.3 million from corporations, foundations and individual donors. Total costs for the project will be $4.5 million. The remaining balance of $2.5 million will come from capital reserves.

New center offers treatment for sexual problems

Needless worry about changes in sexuality that are a normal part of growing older often lead to sexual difficulties in otherwise healthy men, according to Dennis Sugrue, PhD, director of the Henry Ford Center for Human Sexuality. The Center, which offers medical and psychological evaluation and treatment of sexual problems, recently opened a new office in Farmington Hills.

At about the age of 50, a

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Physicians in the News

Sidney Goldstein, MD, head of the Division of Cardiovascular Medicine, Henry Ford Hospital, is a newly-elected member of the Board of Trustees of the American College of Cardiology. As chairman of the College's Manpower Committee, Doctor Goldstein is assessing the country's current and future needs for cardiology specialists. A graduate of Cornell University Medical College, Doctor Goldstein has served as head of Cardiovascular Medicine at Henry Ford Hospital since 1974.

Kevin M. Fickenscher, MD, is the new president and chief executive officer of the newly-named Michigan State University Kalamazoo Center for Medical Studies, formerly the Southwestern Michigan Area Health Education Center. Doctor Fickenscher comes to Kalamazoo from North Dakota, where he most recently served as the Director of The Center for Rural Health at the University of North Dakota, Grand Forks. He was simultaneously associate professor in the Department of Community Medicine and Rural Health, and assistant professor in the Department of Family Medicine at the University. He is a graduate of the University of North Dakota School of Medicine. He served as president of the National Rural Health Association from 1968 to 1987, and is currently a member of the National Advisory Committee on Rural Health, US Department of Health and Human Services.

Vainutis Vaitkevicius, MD, a nationally known cancer specialist (usually referred to as Doctor Vee), is a new inductee to the International Institute's Heritage Hall of Fame. He is physician in chief of The Detroit Medical Center, chief of medicine for Harper-Grace Hospitals, and is chairman of the Internal Medicine Department at Wayne State University School of Medicine. Doctor Vaitkevicius earned his medical degree from Goethe University in Frankfurt, Germany, and completed his internship and residency at Grace and Detroit Receiving hospitals. He has published numerous books and articles, has received many honors, and remains active in 15 professional societies.

Jacob Zvirbulis, MD, a St. Johns psychiatrist, is newly-appointed medical director of the Rivendell Children and Youth Center, St. Johns. Doctor Zvirbulis has over 20 years of experience in working with adolescents and their families. Rivendell is an acute-care psychiatric hospital for adolescents, 12 to 18 years of age, with primary psychiatric diagnoses. He will be overseeing all aspects of patient care at the hospital.

Allen Silbergleit, MD, is the newly-elected president of the American College of Surgeons, Michigan Chapter. Other newly-elected officers include: **Angelos A. Kambouris, MD,** president-elect; **Anna M. Ledgerwood, MD,** secretary; and **John A. Ingold, MD,** treasurer.

John V. Balian, MD, a Rochester ophthalmologist, is very involved with the World Eye Foundation and, as a result, was invited to attend a special reception for friends of the "China Vision" project and members of the World Eye Foundation. It was hosted by the People's Republic of China Ambassador Han Xu. Doctor Balian's professional and personal dedication to the Foundation has taken him to eye hospitals in Shanghai and Beijing where he has examined Chinese medical procedures and reciprocated ophthalmic surgical information.

Jeffrey B. Band, MD, chief, Division of Infectious Diseases and director, Epidemiology Department, William Beaumont Hospital, Royal Oak, is the recipient of a research award from Hoffman-LaRoche, Inc., a pharmaceutical firm headquarted in Nutley, NJ. Doctor Band is one of 10 physicians throughout the US who received awards for scientific achievement during the annual Roche Infectious Disease Research Rounds conference held in May. Doctor Band has donated the award money to support ongoing research activities of Beaumont's Division of Infectious Diseases. In addition to his position at Beaumont, Doctor Band serves as associate clinical professor of medicine at the Wayne State University School of Medicine.

Elissa P. Benedek, MD, director, Research and Training Center, Forensic Psychiatry, Ann Arbor, is president-elect of the American Psychiatric Society. She will begin her one-year term as president in 1990. Doctor Benedek has served as secretary, vice president, and trustee of the 35,000-member national professional organization. She also was chair of the National Committee on Women and has been a clinical professor of psychiatry at the University of Michigan since 1979.

Nicanor F. Castedo, MD, is the newly-named medical director of Adult Psychiatric Services at Havenwyck Hospital, Auburn Hills. Doctor Castedo is responsible for the 55-bed inpatient adult psychiatric program and the 24-patient Day Hospital.

Steven E. Minnick, MD, of St. John Hospital, Detroit, is the newly-elected president of the Michigan Association for Medical Education. Other newly-elected officers include: **Robert E. Reed, MD,** Butterworth Hospital, Grand Rapids, president-elect; **Samuel McMahon, MD,** Ingham Medical Center, Lansing, secretary/treasurer; and **Paula Kim, MD,** Bon Secours Hospital, Detroit, member-at-large.

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man's sexual response undergoes some changes. Most older men can no longer achieve an erection as quickly, and they need their partner to help stimulate them. For men who aren't aware that these changes will occur, the differences can be so disturbing that they begin thinking their sex life is slipping away. Although the changes won't affect a man's ability to sustain a satisfying sex life, worry that they might can plant a seed of doubt, causing a mental block that makes it impossible for the man to achieve an erection.

Men who develop sexual problems as a result of their reaction to these changes usually can be helped through brief therapy.

For more information on the center, call (313) 626-4804. The center, which is part of the Henry Ford Health Care Corp., is located in the Brookfield Office Park, 31500 Northwestern Hwy., Farmington Hills.

Kellogg Foundation grants $10,000 to MSU health program

Healthy U, Michigan State University's nationally-recognized health promotion program, has been awarded a $10,000 grant from the W.K. Kellogg Foundation.

The grant was used to fund a two-day workshop at which community leaders from around Michigan gathered at MSU to discuss strategies for meeting the National Health Objectives.

The objectives, formulated by the Office of Disease Prevention and Health Promotion, serve as guidelines for improving the quality of life in the US. The objectives include such items as reducing tobacco use, improving nutrition, and preventing and controlling cancer.

MSU's Healthy U program is a reflection of both an institutional and individual commitment to health. It addresses those areas of health which are most affected by lifestyle, including stress reduction, substance abuse, safety, nutrition, and exercise and fitness.

Funded in part by a grant from the W.K. Kellogg Foundation, Healthy U has 27 programs operating on campus, each staffed by faculty, students and staff from different departments.

"Bicycle Around Michigan" — and help support the Lung Association

The American Lung Association of Michigan is inviting and encouraging Michigan residents to participate in its "Bicycle Around Michigan" tours to help support the Association.

Registrations are now being taken for the tours, which are sponsored by Mr. Turkey. Two three-day tours are available.

The Leelanau Lakeshore Loop, September 8-10, begins and ends at Suttons Bay. Cyclists, age 18 and up, will tour Michigan's Leelanau Peninsula visiting Lake Ann, Sleeping Bear Dunes National Lakeshore, and Glen Arbor.

The Mackinac Island Tour, September 23-25, begins in Mackinaw City and takes in Cheboygan, Douglas Lake, and a ferry ride for a day and night on historic Mackinac Island. Cyclists of all ages are welcome.

These leisurely-paced tours require no special experience or expensive equipment. The Lung Association takes care of tour planning and provides sag wagons for carrying personal gear, mechanics, and experienced leaders. Each tour includes one night's stay in lodge-style accommodations and a second night in the luxury of a popular Michigan resort.

Orientation sessions will be held this summer in several locations throughout the state to provide information on bicycle safety, training, and tour plans.

The "Bicycle Around Michigan" tours are pledge-based fund raisers to benefit the American Lung

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Association of Michigan. Corporate teams and community groups are encouraged to participate. Prizes will be awarded to cyclists who raise more than $300.

For more information, call the American Lung Association of Michigan toll-free at (800) 678-LUNG. In the greater Lansing area call (517) 484-4541.

U-M researchers discover protein that may prevent breast cancer

University of Michigan Medical Center researchers have moved a step closer to developing a new method to treat women with breast cancer and eventually formulating ways to prevent the disease.

Max S. Wicha, MD, professor of internal medicine and director of the U-M Cancer Center, along with Paul Ervin, a U-M research associate, and a research team have isolated a pure protein they call mammastatin that inhibits breast cancer growth.

"Mammastatin, which is produced by normal breast cells, is a potent inhibitor of breast cancer cells growing in the laboratory," says Doctor Wicha. "Mammastatin specifically stops the growth of breast cancer cells but not cells from other tissues."

In normal breast tissue, cell growth is balanced between growth inhibitors and growth stimulators, while in cancer cells, an imbalance has occurred and the growth stimulator overpowers the inhibitor.

Doctors Wicha and Ervin and several collaborators hope to clone the gene that makes mammastatin, which is in limited supply, so that its effects can be studied in animals and, eventually, in cancer patients.

The investigators have developed a test to measure mammastatin in women's blood. All women, says Doctor Wicha, have some mammastatin in their blood, though at widely varying levels.

"We speculate that women with low levels of mammastatin may be more prone to develop breast cancer," he says. "If this is the case, a scientist could potentially detect and correct a woman's predisposition to breast cancer before the disease occurs.

"I want to caution people that this is just the beginning of our study, although we hope it is a significant step in the effort to combat breast cancers," adds Doctor Wicha. "During the next several years, we need to analyze blood samples of many women with and without breast cancer to determine if there is a correlation between mammastatin levels and breast cancer development."

Computer adds new dimension to cancer treatment

Henry Ford Hospital is utilizing a fascinating new computer system that may offer cancer patients faster and more accurate treatment.

The system, called a microtron with computerized multileafs, is the latest clinical advancement in radiation therapy. The system allows doctors to program the size and shape of the radiation beam to conform to the tumor and surrounding areas requiring treatment.

Using the new system, doctors first plot the location and size of the tumor on X-rays. This information then is transferred to a special computer, which creates a graphic display of the area to be treated. Rows of metal strips, called multileafs, cover the area of the microtron that emits the radiation. When the patient is ready for treatment, the computer programs the microleafs to form a shape that resembles the area to be treated. The microleafs block the radiation from hitting surrounding healthy tissue. ■

Michigan State Medical Society

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THE REALITIES OF PRACTICING MEDICINE IN THE 1990s

A LOOK AT THE TRENDS

By Billy Ben Baumann, MD

Maintaining a healthy medical practice in the 1990s and beyond is going to require increasing amounts of a physician's time and energy. Employee relations, financial management, third party relations, patient flow, scheduling, and strategic planning are some of the areas on which physicians will need expert advice and information.

In the past, physicians were able to maintain viable practices without the need to pay much attention to management. Increased competition from a number of sources, including other physicians and hospitals, as well as surveillance and scrutiny by third parties, has drastically changed that situation.

Physicians must spend some time analyzing and developing strategies if their practices are to survive. Personnel management, Section 89 non-discrimination clauses, right-to-know laws, and employee relations all are matters which physicians will have to deal with. Marketing and promotion is another area about which physicians will need specific information.

Recent information from Medical Economics indicates that, for marketing purposes, there are two distinct patient populations: people under age 45 and people over age 45. Each have different and identifiable standards for determining the types of doctor services they expect. Just knowing this, and having a minimal amount of facts about the characteristics of a physician's patient load, can assist the physician in making appropriate decisions regarding the future direction of his practice.

With this in mind, the Physician Service Group, Inc., (PSG), a subsidiary of MSMS, has made physician support and practice management its primary goals. Physicians on the PSG Board of Directors recognize the value of physicians' time. Many times, PSG will spend many hours — or even years — investigating a product or service before it is endorsed. Thus, those many physicians who do not wish to spend their time and energy "shopping around," can rest assured that PSG already has done most of the work.

A recent example of PSG's support to physicians and their practices was a questionnaire and resulting consultation regarding the Section 89 non-discrimination clauses for employee benefits. (Every physician who is an employer should be looking at the new requirements of this law and evaluating how their employee benefit program should be adapted to meet the requirements.) Some physicians opted to seek — and pay for — advice from private consultants, attorneys, or accountants regarding the law. Those who turned to PSG, on the other hand, received a very valuable analysis of their own potential needs under the law simply as a "fringe benefit" of their MSMS membership.

Many changes are occurring in the medical arena — and in the world — and physicians need to know about them. PSG is committed to providing physicians with the information they need to adapt to these changes and to run their practices effectively.

This month's cover story is devoted to practice management to help provide physicians with a more clear picture of the challenges which lie ahead. A number of pages also are devoted to describing the many services and benefits offered by Physician Service Group, Inc. I encourage you to read on. ■

Doctor Baumann is president of Physician Service Group, Inc.

1990's

EXPERTS OFFER ADVICE ON PRACTICING IN THE 1990s

What is the most important objective a physician should focus on over the next five years to maintain a healthy practice? Physicians Service Group recently sought an answer to this question from eight individuals — all of whom will be actively involved in the development of PSG or who will be in a position to affect physician practices over the next five years. Their responses follow.

Gayle M. Fankhauser
Department Director
Department of Practice Management
American Medical Association

"In general, 80 percent of physician income is paid by third-party payors. As health care costs continue to rise, third-party payment arrangements will become increasingly complex and requirements will change rapidly. These changes will impact both the business and clinical dimensions of medical practice. In the future, physicians will need to focus on staying abreast of these changes and playing a more active role in managing the way claims are processed by their office staff."

William E. Madigan
Executive Director
MSMS

"Physicians must have a reliable information source on what is happening in the continually changing marketplace not only locally, but nationwide. MSMS is, and will continue to be, one of the few reliable sources of information for physicians.

"Physicians have got to spend a predetermined portion of their time on the business side of their practice — and that is easier said than done. MSMS has been, and will continue to be, a valuable help to physicians in improving their practice environment — its efficiency and its quality. In addition, MSMS is a trusted source of financial planning advice."

Robert E. Paxton, MD
MSMS President

"It is impossible to narrow the objectives to one. Furthermore, from my perspective, these objectives have not changed much over the years and remain quite basic.

"First and foremost, it is essential to establish a strong doctor/patient relationship based on a caring attitude. I know that many of the forces in today's society, especially the malpractice crisis, tend to destroy that traditional relationship. However, to maintain a healthy practice we need to cement our relationship with our patients. We need to be kind, understanding, gentle and human...hold a hand a little longer, touch a shoulder gently, take a few extra minutes to talk.

"Dovetailing with this concept is the continuing need to deliver quality care — an objective always germane to a healthy practice.

"Finally, I think to give balance to the objectives needed, it is mandatory that the physician take pride in his or her profession, fight to maintain professionalism, and contribute towards community enrichment. To achieve success, we must underline the need for physician involvement in the democratic political process. A blending of all these components will indeed ensure a stable and rewarding practice leading up to the 21st Century."

Earl Romans
Earl L. Romans, PC
Certified Accountants & Consultants
Southfield

"During the next five years, physicians will need to devote more time and attention to the financial management of their practices. Of most concern should be cash flow, accurate billing and the timely collection of receivables. The life blood of a good business is its ability to generate profits and collect and reinvest its capital for future growth."

Larry Sell, MD
Senior Vice President/Medical Director
Blue Cross/Blue Shield of Michigan

"We're in a revolutionary environment that is imposing limitations on the activities of physicians, and it quite likely will continue for the next three to five years. The two most obvious causes are: (1) Excess capacity in the health care system; and (2) The attraction of selective contracting for employers who are paying the bills and driving the system today.

"The winners among physicians will be those who deliver top quality care within the scope of their training and specialty and meet the current and future utilization review standards deemed appropriate by their peers."

Dawn E. Springer, MD
Mason Family Practitioner
Chairman, MSMS Committee
on Concerns of Women Physicians

"What a complex question for a private practitioner to answer! Immediately, I think about having sound financial advice and a competent staff who can manage the 'correct patient flow.' It is also imperative to have up-to-date equipment in pleasant surroundings in the appropriate part of town. Physicians must be willing to use the many marketing tools available to them for promoting their practice.

"Having taken marketing courses in undergraduate school, I still believe that the key to a healthy practice is the physician and the way in which they extend to each patient sincere and competent care. Ideally, this attitude then enhances the other considerations so that there is mutual trust, with both the physician and patient being the winner."

Diana Sikes
Linda Buck
Vice Presidents, Marketing
Medical Marketing Products, Inc.
Farmington Hills

"With increasing competition and shrinking dollars, the clear winner in five years will be the physician who plans his practice today to attract fee-for-service patient volume. This plan should include networking with important referral sources, using the hospital's resources to gain new patients, maximizing existing patients through better communications and recall programs, and building services that fit the needs of your community. The key is to plan your future for profits and volume."

Richard A. Stone, MD
Mt. Clemens Dermatologist
Chairman, MSMS Young
Physicians Section

"I am concerned that the physician's relationship with his or her patient, hospital, and insurers is dramatically evolving. In many managed care programs, the physician, for the first time, is placed at financial risk in the delivery of care.

"It is my opinion that physicians must, in the next five years, focus on those values and standards which brought the profession to the high respect in which it is regarded.

"Today, I find our patients highly educated and active participants in health care decisions regarding themselves and their families. They easily see through any compromise in the quality of care that is provided to them. Unless physicians maintain, without variance, values and standards which cannot be compromised by economic pressures, there is no way to maintain a healthy practice or, for that matter, the future of medical care as we know it."

SERVING THE NEEDS OF PHYSICIANS THE NUMBER ONE GOAL OF

PHYSICIAN SERVICE GROUP, INC.

By Peter Marabell

GORDON GEKKO WAS RIGHT. "Look kid," the stockbroker extraordinaire said to the young novice in Wall Street, Oliver Stone's 1988 film about high finance and high living. "The most valuable commodity I know of is information." That's true for the world of business, of course, but it's also true for the practice of medicine.

"The future lies with those physicians who have easy access to information," says John Richards, general manager of Physician Service Group Inc., the service subsidiary of MSMS. PSG recognizes the importance of strong practice management for solo and group practitioners alike. Ineffective management costs both physicians and patients time and money, but PSG helps physicians overcome managerial problems with creative solutions. Not so long ago, physicians often found that the business side of their practice pretty much ran itself, leaving them with much time and energy to devote to their patients. Today, however, things have changed dramatically.

Like so many other areas of modern American society, the practice of medicine has become quite competitive. The number of physicians has markedly increased, the complexity of insurance regulations is enough to try the patience of a saint, and watch-dog agencies, while calling on medical personnel to always act responsibly, sometimes demand what seems to be the impossible.

The net effect is that it's getting tougher to balance the business and the patient-care sides of many medical practices. What it often comes down to is a lack of time and knowledge, not desire.

"We know that most physicians want to make their own decisions," says Richards, "but the time it takes to stay informed, to stay knowledgeable, is too demanding for even the most conscientious physician." How many physicians, after all, could discuss with confidence the latest rules and regulations of Medicare compliance, or the current procedure terminology codes, or recent changes in the tax code?

"It's PSG's obligation to service physicians," Richards adds. "PSG wants to offer top of the line products and services to help physicians manage their practices." At PSG, careful thought is given to the needs of medical personnel. The sole purpose is to service those needs, to fill the gaps created by a rapidly changing society and the demands of the profession.

"We know that it takes time — valuable time — for a physician to find the right service to solve a particular problem. PSG has the time...we can take the time that busy physicians just can't seem to find." From seminars on personal and professional financial management, and consultations by recognized experts, to product endorsements, PSG listens to the people who must tackle problems in the office on a daily basis.

Before a product or service receives the MSMS endorsement, for example, an organization or company is carefully scrutinized by the folks at PSG. If physicians are to have confidence in PSG recommendations and endorsements, then PSG must have confidence in the organization it endorses. PSG looks for companies that take the needs of physicians seriously.

"We turn down products and services at the rate of ten to one," Richards says candidly. "We've got to be sure that organizations focus on medicine the way we do." PSG insists that companies being considered for endorsements are sound businesses with a solid record of longevity and, most important, continuing involvement with the medical community. The road to a MSMS endorsement is a deliberate and thoughtful one.

MEDICAL BILLING SERVICE

A few years ago, it was increasingly obvious that office billing headaches were rapidly becoming nightmares. The traditional method of posting-by-hand, mailing-by-hand was simply too clumsy and slow for most medical offices. For awhile, at least, it was thought that in-house computer systems were a 21st century solution for the overworked office staff. It soon became apparent, however, that in-house computers created more nightmare-like problems than they solved.

PSG began a careful search for a billing company that understood the special requirements of the medical profession, that was a business on solid footing, and had a track record of handling medical billing problems efficiently. The Medical Billing Service of Southfield eventually won a MSMS endorsement. For better than two years now, MBS has met the needs of its Medical Society clients around the state. Unsolicited letters of satisfaction to MBS and MSMS are testimony to the quality of MBS work and to the seriousness with which MSMS regards its endorsements.

PSG also administers the MSMS-sponsored health insurance for physicians and office staff at rates competitive with other carriers and far cheaper than individuals could acquire on their own — even if they had the time to shop around. (Details on the health insurance program and the recently introduced Delta Dental plan appear on page 22.)

CREDIT CARD PROGRAM

One of the more creative benefits from PSG is an arrangement worked out with Comerica for a merchant credit card. Through Comerica, physicians can offer to their patients an alternative method of payment — VISA and MasterCard. Comerica will electronically transfer funds to the physician's account, usually by the end of the business day. This unique feature translates into cash in the bank almost daily. The phrase "cash flow" takes on a whole new meaning when the folks looking for — and implementing — solutions to that long-standing problem really appreciate its unique impact on medical professionals.

A more individualized method of solving office problems is by private consultation. Recognized experts, referred by PSG, go to the physician's office on a fee-for-service basis and study the individual situation. Consultants frequently examine appointment scheduling; the accounting system and financial flow; cash management; billing and insurance forms; and patient flow. After careful analysis, the consultants make their recommendations for improving cost effectiveness and efficiency.

PRACTICE MANAGEMENT SEMINARS

Many of the women and men who are consultants also participate in PSG's Practice Management Seminar Series. Many practitioners find that their particular problems do not require the attention of the in-office consultation. Still, problems need solutions, and the Seminar Series was developed to reach the widest number of physicians, spouses, staff people, and residents.

"In today's changing environment," wrote Fred W. Bryant, MD, MSMS immediate past president, "running a successful practice requires more than merely providing quality medical care...it is important to possess strong financial and managerial skills." The aim of the series is to "offer results-oriented strategies to maximize revenues, while improving patient services."

Under the guidance of Amy Fistler, assistant to PSG general manager Richards, the Seminar Series has grown from just 12 last year to 34 in 1989. A few of the seminar titles should convey the range of issues covered: "Advanced CPT Coding Workshop," "Financial Planning," "Retirement Planning," and "Medicare Update." But the seminars are not limited to nuts-and-bolts issues alone. Also on the agenda for 1989 are such sessions as "Stress Management Before Impairment," "Fostering Positive Physician/Patient Relations," "Young Physicians Conference," and "Starting Yourself in Medical Practice."

The scope of the sessions recognizes that a physician's professional and personal life need equal attention. The balance between the business side and the patient-care side must be expanded to include the physician's family and home life. All the old cliches about "all work and no play" have more than a ring of truth to them. Quality, attentive health care is best given by those practitioners who realize the value of their time out of the office.

"Stress Management Before Impairment" is one seminar that deals with balance in the physician's life. It comes as no surprise that the practice of medicine produces stress, but this session focuses on the role stress plays at home as well as in the office. It also suggests strategies for coping that will benefit the physician, his or her patients, staff, and family.

The seminars are conveniently scheduled from mid-winter through late fall. Most of them are held in the Detroit metropolitan area, Grand Rapids, Flint, and Kalamazoo. A few of the more popular seminars — "Third Party Reimbursement and Coding" and "Medicare Update," for example — are scheduled several times during the year. MSMS has detailed brochures outlining the 1989 seminars.

SPECIALTY GROUP ADMINISTRATION

While PSG is constantly looking for new ways to assist practitioners in their offices, the needs of medical associations and societies have not been overlooked. There are any number of them around the state that require high quality administrative and clerical services. The problem, of course, is that some of them lack sufficient revenue to support a full-time staff. And that's where PSG comes in.

"We employ first-rate people who work for each specialty group on a part-time basis," says Richards. "It's true," adds Caroline Kimmel, who along with Viola Heins, has overall responsibility for the specialty group administration program. "We don't work for one boss, we work for many bosses."

PSG negotiates individual contracts with specialty groups. Basic services offered through the program include membership application; mailing-list processing; mailings; dues billing and collection; and membership ledger and file maintenance. Some optional but still essential services include meeting preparation; name-tag preparation; and minute keeping.

"Having us here on a part-time basis is so much less expensive than hiring a full-time staff," suggests Heins. "The most valuable thing we offer," Kimmel adds, "is continuity." Association leaders can change frequently, and the PSG staff helps

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facilitate that transition. "Our clients build up trust in us, and we develop trust in them," Kimmel concludes.

FUTURE DIRECTIONS

Certainly, trust and confidence are as important to physicians as they are to specialty groups. But the PSG staff know they must keep their eyes and ears open to what physicians are concerned about, and they must listen carefully to learn what the needs of the future will be.

And where is the future headed at the moment? According to Richards, something called "electronic networking" is the wave of the future. Basically, what electronic networking means for PSG and its members is that one endorsed service will "talk" with another endorsed service to facilitate and speed up essential transactions without the necessity of clients becoming directly involved.

A case in point is the recent agreement between two PSG endorsed services, Medical Billing Service and IC System Inc., an 1,100 outlet, nationwide collection firm. PSG understood that collecting late bills is a touchy subject most practitioners and staff people would rather delay until the proverbial tomorrow. No one denies, however, that physicians, like everyone else, have a right to be compensated for services rendered. It's just that no one wanted to do it, so PSG stepped in and helped develop a connection between MBS and IC System that takes the sting out of debt collection. Simply by telling MBS what the parameters are, physicians let MBS and IC System handle late collections automatically.

Whether it's the same-day transfer of funds into the physician's account by Comerica or the collection of late bills by MBS and IC System, electronic networking is here to stay. The most fascinating thing, however, is that its potential has only just been tapped.

"Electronic networking is only the beginning," Richards says. "Our market research is talking and listening to physicians. We're always brainstorming ways to save them valuable time. Physicians have to stay on top of things, they've got to stay informed."

In a recent speech in Traverse City, Governor James Blanchard said, "We're in the information age, like it or not. We've got to be prepared."

PSG is ready today," says Richards emphatically. "We'll be ready tomorrow." ■

Peter Marabell, a Michigan State University professor, is a freelance writer and is general manager of GPM Communications, East Lansing.

PSG ENDORSED SERVICES AT A GLANCE

Bell Atlantic-Tricon – medical equipment leasing program.

IC System, Inc. – billing collection; Medicollect — an online collection service.

Medical Billing Service, Inc. – complete online computerization billing program.

Comerica Bank Merchant Credit Card – enables patients to pay at time of service with either MasterCard or Visa.

MSMS Personal Gold Card – offers larger credit lines, up to $15,000 and lower interest rates on unpaid balances.

The Equitable Pension Plan – retirement plan for MSMS members.

Randolph Medical Group Purchasing Program – discounted rates on medical and office supplies.

Allied Office Systems – office interior design services.

Discount Magazine Subscription Service

Practice Management Consultant Referral Service

Educational Seminars for MSMS members and their staff – over 35 programs offered annually on a full range of topics pertaining to running a medical practice and timely issues effecting the practice of medicine.

PSG administers and markets the MSMS group health insurance benefit program offering:

Blue Cross/Blue Shield – three-option program.

Delta Dental Group Insurance Plan

Association Administrative Services – PSG provides administrative services to twelve specialty and allied organizations.

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PSG SEMINARS ADDRESS A VARIETY OF TOPICS

To help women physicians meet the many challenges they face in organized medicine, Physicians Service Group held a seminar "For Women By Women" April 6 in Ann Arbor. Seminar topics caught the attention of many attendees including Martha L. Gray, MD, (left), an Ann Arbor internist, and Cassandra M. Klyman, MD, (far right), a Bloomfield Hills psychiatrist who spoke at the seminar.

"Defensive Planning: Protecting Your Assets in Michigan's Liability Climate," was the topic of a PSG seminar held May 3 in Grand Rapids. During a break in the seminar, speaker Eugene F. Lovasco, JD, CPA, CLU, (left), took a moment to chat with Jerry E. Van Kuiken, MD, a Grand Haven pediatrician.

Marguerite R. Shearer, MD, a Dexter family physician and member of the MSMS Board of Directors, addressed attendees at the "By Women For Women" seminar held in Ann Arbor in April.

Topics addressed at the May seminar on defensive planning generated a small group discussion during a break. Pictured from left to right: Seminar speaker Earl L. Romans, CPA, of Earl L. Romans, PC, Southfield; Robert W. Jasinski, MD, a Holland radiologist; seminar speaker Julius Giarmarco, JD, LLM, of Giarmarco and Bill, PC, Troy; David G. Booth, MD, a Muskegon family physician; Daniel J. Weiner, JD, of Shafer & Weiner, PC, (second from right); and Jerry E. Van Kuiken, MD, a Grand Haven pediatrician.

MSMS Group Insurance Trust Provides Service With a Capital “S”

By Michael R. Kelly

Service to physicians, their families and their employees has been the main purpose of the MSMS Group Insurance Trust since it began in January 1987. Service continues as the main purpose of the Group Insurance Trust today.

A large part of the service we provide is the administration of the health benefit and the recently introduced Delta Dental plan. Not to be overlooked, however, is the “personalized” touch we provide our members — an extremely rare attribute in the insurance business.

Our staff includes three highly-trained service representatives whose sole purpose is to answer any questions or concerns our physicians or their employees may have with regards to their Blue Cross Blue Shield health benefit or their Delta Dental benefit.

Since 1987, over 20,000 calls have been received on our toll-free (1-800-942-4141) line. This represents an average of 865 inquiries per month that the Group Insurance Trust is servicing! In order of frequency received, inquiries can be placed in the following categories:

- Explanation of coverage
- Request for membership change (i.e. adds, deletes, address changes, and enrollment in Medicare supplemental coverage)
- Questions regarding eligibility
- Requests for applications
- Billing questions
- Questions regarding insurance rates
- Requests for additional ID cards

As chief of insurance marketing, I am always ready and willing to come directly to a physician's office for an explanation of benefits offered by MSMS. The benefits are many, the service is first-rate.

For more information on the MSMS Group Insurance Trust, call our toll-free number. ■

Michael Kelly is chief of insurance marketing for Physician Service Group Inc., a subsidiary of MSMS.

Cover Story

PRACTICE MANAGEMENT AUDIT — A PAINLESS, AND PROFITABLE, PROPOSITION

By Chad B. Munger

“Audit” is a word which should no longer strike fear in the heart of a physician. In fact, doctors may even find themselves asking for this once unpalatable invasion.

Unthinkable, you say? Probably, if you're thinking of an audit that involves the IRS and long hours with an accountant.

No, the type of audit more and more doctors may soon be asking for is a practice management audit (PMA). The single goal of this type of audit is to help doctors make their practices run more efficiently.

A well-run practice is both profitable and one of the best ways to ensure delivery of quality medical care. Regrettably, the challenge of running an efficient business is a reality many physicians have never been trained to face. A practice management audit is one way to get a little help.

The “auditors” at Medical Consulting Services, with offices in Lansing, Southfield and Grand Rapids, are experts in helping physicians and their staffs become more efficient.

“There are more physicians who need this service than use it,” says John Anthony, director of Medical Consulting Services, a firm recently endorsed by MSMS as a leader in practice management consulting. “Most physicians are simply unaware of the service. Some just don't recognize its value.”

A VALUABLE PROPOSITION

The value of a practice management audit is found not only in the additional revenue it helps generate, but also in the happier staff and more reliable care to which it ultimately leads.

Generally, a practice management audit is a day-long event. Over the course of an audit, every aspect of a medical practice — from telephone conversations to exam room organization — is evaluated.

Although the details of an audit vary from practice to practice, the following is an approximation of the steps each audit moves through.

STEP ONE

The busiest day of the week is generally the one which is chosen for the audit. “We go the day the most physicians and patients are present,” says Anthony. “We want to see the system under stress.”

One of Medical Consulting Services six auditors will begin the audit by touring the office. This helps the auditor to get a feel for the layout and personality of the practice. Harmonious interaction of people, processes and equipment are crucial to running an effective practice. The systematic changes that will ultimately be suggested for a practice are largely dependent on these factors. According to Anthony: “You design an internal system that matches the personality of the practice, as well as the needs of its patients. To do that, you must study the idiosyncracies found in every office.”

STEP TWO

After getting a feel for the space and the people who work in the office, the auditor begins a more tangible evaluation of how the practice is run. This usually means an evaluation of office personnel.

The number of people employed and their duties are evaluated to make sure there are enough, but not too many, people working to run the operation efficiently. Employees may be evaluated as to how knowledgeable they are about their job, whether they are at the right place at the right time, their ability to work within a reporting hierarchy, their ability to work with fellow employees, and very importantly, their influence on patients. Is it positive or negative?

An objective evaluation of these characteristics is sometimes possible only from a person removed from the framework of the practice. A practice management consultant is uniquely suited to provide this kind of critique.

STEP THREE

A "typical" audit might continue with an evaluation of the financial position and practices of the office (the consultants working for Medical Consulting Services all have degrees in business and/or have experience working in medical offices). An auditor will first look for areas where the practice might improve its flow of income. For instance, the billing process is usually an area which can be streamlined. The auditor will look to see if delinquent accounts are being followed up and rejected or if pending claims are re-submitted. In addition, the auditor will determine if staff is asking for payment correctly from patients. The practice's relationship with third party payers will be looked at for possible improvement.

After five years and hundreds of audits, Medical Consulting Services has a lot of experience with the quagmire of third party claim forms — knowledge which itself can be worth the cost of an audit.

A practice's pension and profit sharing plans are scrutinized and in general the auditor looks for ways a practice's money can make money.

The negative side of a practice is not all that is looked at. What is being done correctly is as important as what is being done wrong. In financial terms, that means identifying trends in cost and revenue. Trends in revenue production, as with Blue Cross and Blue Shield or lab work, are identified so they may be more effectively utilized. Trends in excessive cost also are identified so they may be minimized.

THE FINAL STEP

After a look at the people and the dollars involved in a practice, the auditor will generally conclude with a look at office logistics. Common, seemingly mundane, procedures such as answering the phone and scheduling appointments are critical to keeping an office running smoothly. The auditors look for ways to keep patients moving through the practice continually. They also look at the way patients are worked in on an emergency basis, as well as how receptionists handle questions. Are they trying to answer questions themselves or do they always refer to someone else?

When and why doctors and nurses are interrupted and how patients are prepared for exams before the doctor arrives are two other examples of the auditor's focus. Efficiency is what the auditor tries to promote in every aspect of the practice.

The areas listed above are just a few examples of things which an audit will address. The unique character of each practice will mean a slightly different set of problems and solutions for each one.

"Each office has it own characteristics and qualities," says Anthony. "Medical Consulting Services tries to design its solutions around the personalities and wishes of the people involved at each practice. We try to identify what is working and what is not working in each office and then make recommendations which can be easily adopted and implemented. If you go in with a pre-set solution, then you will make recommendations that have no chance of being instituted — and you've wasted time and money."

A practice management audit results in either a debriefing at the end of the day or a written report containing suggestions for improvement. The entire proposition is quite painless. The cost of an audit: $125 per hour for a senior consultant or $45 per hour for a junior consultant.

With profit margins being squeezed by rising costs and reduced third party reimbursement, the only way to increase profitability is to become more efficient. Every medical practice can benefit from being more efficient. A practice management audit from Medical Consulting Services is an excellent way to achieve this. ■

Chad Munger is an East Lansing-based freelance writer.

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Consult a Professional Designer
to Help Plan Your Office Space

EXTRA WORK AREA
EXTRA WORK AREA

By George Tiedgen

Editor's note: *MSMS recently endorsed Allied Office Interiors, a Michigan-based design, space planning and furnishings dealer. The company represents Steelcase, Stow & Davis, Milliken and other industry leaders, and has a large resume of design clients of all sizes and types. It is among the top 100 furniture dealers in sales volume in the nation. In the following article, Allied's vice president of marketing examines the concept of space planning and its usefulness in the medical office setting. Those with questions regarding Allied Office Interiors are encouraged to contact John Richards at MSMS.*

In our business – space planning – we often get involved in planning and specifying professional medical offices. Although every facility is different and each situation is unique, there are recurring issues that surface, whether the client operates in a clinic, an HMO, a private practice, or in some other health care arena.

Following are some of the most commonly asked questions we at Allied Office Interiors encounter, with answers that should prove useful.

Q: We've outgrown our (office) space and have decided to move our practice. How do we determine how much space we will need?

A: This is an excellent question, since wrong space decisions are generally expensive. Whether buying or leasing, space is an investment and the cost of moving from, adding to, or renovating inadequate space can be prohibitive.

Generally, medical professionals have a good handle on how much space is required for exam rooms, special equipment and other technical areas. We find we are most frequently called on to help reconfigure public and business areas, which often are treated as an afterthought in the original space evaluation. In these cases, we are usually asked to plan the proverbial ten pounds of requirements into a five-pound container. Built-in counters that seemed like a good idea are inadequate for storage and other needs. Staff additions have made the business office cramped. Filing needs were underestimated, and waiting rooms and other public space are too small.

The best way to avoid these problems is to get a professional designer involved as early in the facility planning process as possible. By approaching the task from the "inside out," a good designer can send the prospective tenant or owner into the sometimes bewildering real estate world armed with the necessary square footage and cost information to make an informed business decision.

Q: How do I select a "good" designer?

A: First, look for a designer instead of a decorator. Decorating is an aesthetic function; design is a business proposition that includes aesthetics. What's most important is to get your needs defined first, then apply the colors. Form really does follow function.

A good designer will ask questions and listen. How are insurance and patient records handled? How much growth space is needed? What is current staffing and what personnel additions are planned? Who needs privacy? What people need to be adjacent? What are the conference needs? What types of patients or clientele are being served? What are the budget restrictions? It's imperative that a designer truly understand organizational needs in order to do a good job for the client and help them attain their objectives.

Good designers will understand product and space applications, and the resulting good work will gain them a following. Word of mouth from satisfied peers will yield good contract designers, or a prospective client may inquire about a well-designed space they've personally seen. Professional affiliations and associations, such as MSMS, are another good source. I

Continued on page 26

Continued from previous page

am pleased to announce that Allied Office Interiors is a newly-endorsed service of MSMS.

Once you've found a viable design candidate, interview them and ask questions. Ask them how they'd approach your special needs, and ask for references. Above all, determine that they're really listening to you before they try to sell you.

Good design is really a business partnership between client and planner, not a master/slave relationship. The client knows what they do for a living, and the designer understands space. By working together as partners, they can form a comfortable, productive relationship.

Q: I want my facility to present a solid, attractive image, but I don't want to create a Taj Mahal. What do I do?

Q: I don't want my lower income clients to think their money is financing a palace when they see my offices. What do I do?

Both of these questions are variations on a concern we've noticed regarding image, and are reflective of the fact that marketing has become a fact of life in the health care field. Many factors influence what a businessperson wants their facility to look like — geographic concerns, age, gender, sex or income of primary clientele, types of services offered, and other demographic considerations. Good designers understand that it's bad business and bad marketing for any professional to ignore this very real business consideration.

Once again, the key is good upfront planning. While office furnishings can seem expensive, they actually represent a small portion of the overall operating budget, and can significantly leverage space, building and people costs. Good designers know this, and they know how to plan for this in product application. Inexpensive doesn't have to mean poor quality, and solid and attractive doesn't have to translate into prohibitive cost.

A good designer is better positioned to evaluate available, appropriate product than is a client, who will tend to look at price only when faced with an array of product choices. In short, they can plan for function and budget needs without sacrificing image.

Q: Why should I pay for design? All I want is a standard doctor's office?

A: First, professionals understand that nothing is ever free. Firms that say they'll "donate" their time always have a way to recoup their "gift" — usually in the cost of the product they're hoping to sell. A designer is retained for the duration of the project and beyond. Designers with an uncompensated investment in time are not generally willing to spend a lot of it to assure the success of a project. Therefore, it's not cost effective for an uncompensated designer to approach planning from a needs orientation.

Time also is money to the client, especially in the medical profession. Doctors are very busy, and have enough of a challenge allocating their professional time to medically related demands. They certainly don't have the time necessary to deal with the disruption and organizational problems caused by misspecification and design error. The professional designer is paid to solve problems before they occur.

Second, while there can be commonality in office function, there is no "standard" medical office. As illustrated earlier, there are enough variances in the needs of different businesses to make each situation unique.

When laypeople attempt self-diagnosis based on what they know about medicine, the toll exacted can be devastating. Businesses that seek to solve their facility needs without the assistance of a professional planner also usually pay a high price. ■

George Tiedgen is vice president, marketing, Allied Office Interiors.

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Allied Office Interiors is endorsed by the Michigan State Medical Society Physicians Service Group. For more information on special discounts and services to MSMS members, contact Jim Trebilcock at (517) 882-8030.

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Practice makes perfect

D. Elizabeth Knuth, Director
Practice Management
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Liz Knuth has provided professional consulting for both large and small medical practices, as well as hospital-based, ambulatory care and residency programs. With over 15 years experience in the industry, she has garnered extensive, hands-on knowledge of group practice management, with particular emphasis on personnel, financial and automated systems. Below, Liz answers some commonly asked questions by physicians about managing their practice.

■ How can I run my office more efficiently?

One of the most common problems we observe in physician offices is that no one particular person is in charge. Instead, everyone does "a little bit of everything." This system does not work. Each member of your staff must fully understand their role in the office and be accountable for individual work assignments. This ensures that all jobs are handled in a timely and orderly fashion. When duties are not assigned, the unpopular jobs, including billing and receivables management, don't get done. Remember, even though a doctor's office is considered a relatively small operation, it is a business nonetheless, and should be treated like one.

■ How do I know I am optimizing my reimbursement?

A common method for optimizing reimbursement is to develop a collection percentage for the practice or review the percentage of charges that are actually being collected. However, this method alone is not enough. Your office needs to look at the accounts receivable totals and know how many days, on the average, it takes to collect an account. Further, the age of the account is important too. Generally, the older the account the less likelihood there is for collection. In many offices, accounts receivable follow-up on unpaid insurance claims is not done, and a lot of the blame is placed (unnecessarily) on third party payers. Because it is becoming increasingly difficult to bill for physician services, staff must be properly trained and aware of any changes in third party regulations in order to continually improve the collection process. Therefore, accounts receivable management must be a part of the daily operations.

■ How can I upgrade my fee profile?

In most practices we've reviewed, fees are set arbitrarily. Setting fees too low can cost a practice through lost reimbursement. Setting fees to high can place an unreasonable burden on your patients. Developing a fee schedule that will maximize reimbursement is not a simple matter. Several factors must be evaluated to determine which fee is appropriate for which service. Once an office has developed a fee schedule, it needs to be monitored on an ongoing basis.

■ What is the future of Medicare?

The government has agreed on a $2.7 billion reduction in Medicare spending, which means physicians and staff have to be on their toes to ensure that accounts receivable are managed well and coding is accurate. Medicare's new regulations regarding diagnostic coding (ICD-9-CM) means that more claims will be rejected if your staff does not understand and comply with requirements. For example, if your office uses a four digit code when a five digit code is available, Medicare will return the claim for proper coding. And rejected or returned claims mean payment delays for the practice.

■ How can I be sure our computer system is being properly utilized?

One of the most common misconceptions about computers is that they are an immediate panacea to any organizational problems. However, in many cases the office staff never fully understands or properly utilizes their system. For example, in one office, over $50,000.00 was lost because of a failure to verify codes. One physician's accounts had never been billed to Blue Cross/Blue Shield because the doctor's ID number was incorrectly entered. It is best that at least one to two people be fully trained and responsible for the maintenance functions of the computer. Coding dictionaries should be consistently scrutinized for accuracy.

If you find yourself asking these questions, maybe it's time to take a closer look at the dynamics of your medical environment. Let the Practice Management experts of SCMC help boost your practice income, control your expenses and improve patient relations through a comprehensive assessment of your facility.

If you would like a free consultation, contact Elizabeth Knuth at 647-0004 or 1-800-456-3128. We'll make your practice work for you.

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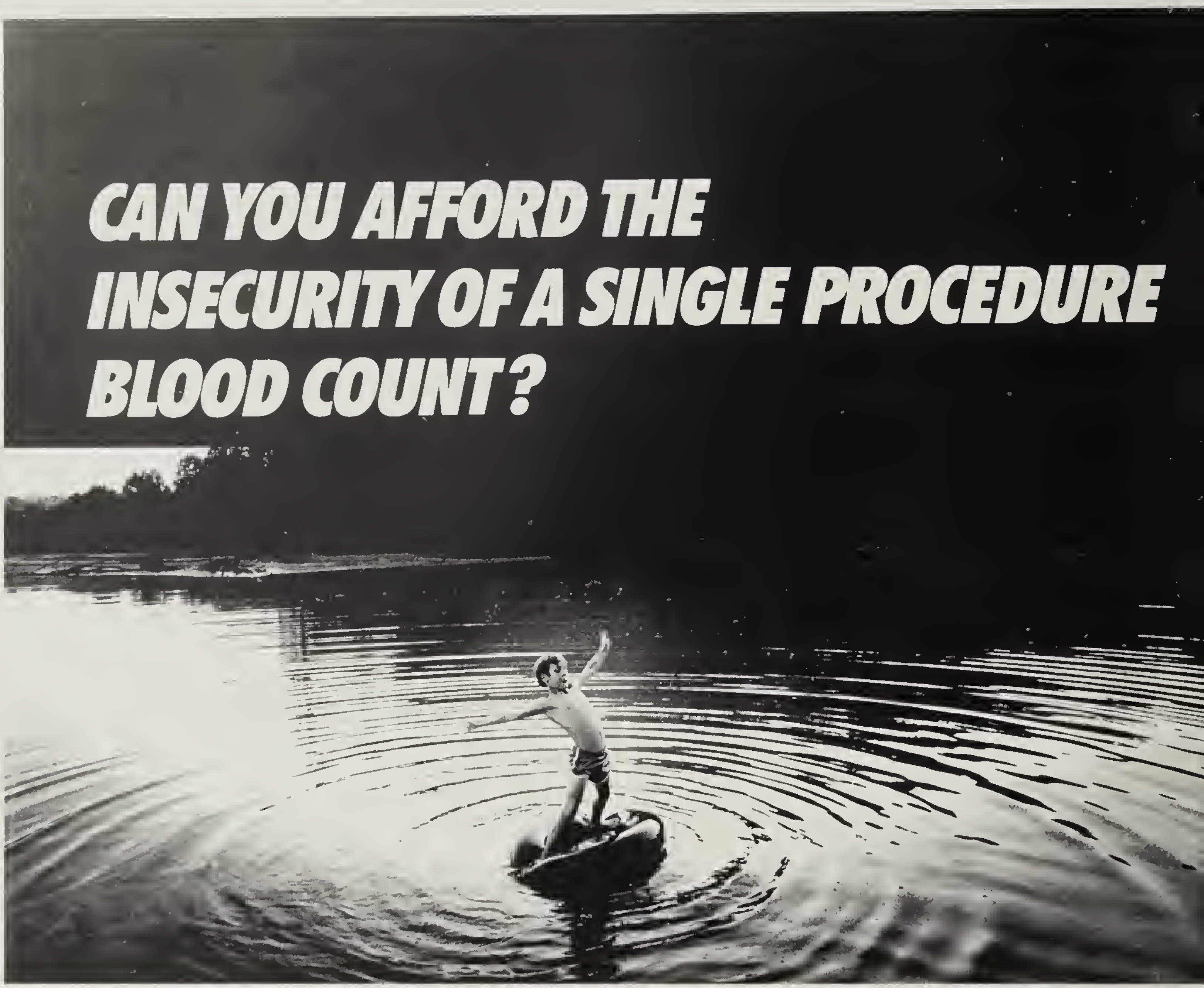
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Doctor Todd

Calls for Unity Among Specialty Societies

The MSMS Committee of Specialty Society Presidents hosted AMA Senior Deputy Executive Vice President James Todd, MD, on May 11 at MSMS Headquarters.

Representatives of the MSMS Board of Directors, the physician insurance companies, state government and the Michigan Hospital Association also were invited to hear Doctor Todd talk about the AMA/Specialty Society Liability Project. The plan has three basic components: (1) An administrative system for resolution of disputes with the workers' compensation program as its precedent; (2) Recodification of liability standards based on physician-established medical treatment parameters; and (3) The documentation of physician competence. Doctor Todd said the plan would move cases out of the courts and redefine liability standards. "The plan speaks well for the ability of the profession to get together and get significant results," Doctor Todd said.

Doctor Todd also discussed the RBRVS and the need for physician unity at a time when external forces are pulling the specialties away from one another. ■

Doctor Todd discussed the AMA/Specialty Society Liability Project with the MSMS Committee of Specialty Society Presidents. Along with Committee members, the MSMS Board Room was filled to capacity with special guests.

Doctor Todd (center) met with MSMS leadership before the Committee of Specialty Society Presidents meeting on May 11. To his left is MSMS president-elect Susan Hershberg Adelman, MD, and to his right MSMS President Robert E. Paxton, MD. Standing behind Doctor Todd (left to right) is: MSMS Assistant Director Kevin A. Kelly; MSMS Board Chairman Frank B. Walker, MD; MSMS Immediate Past President Fred W. Bryant, MD; and MSMS Executive Director William E. Madigan.

If the alternative AMA/Specialty Society plan were in place, physicians would be free from liability if they documented appropriate treatment under physician-prescribed parameters, Doctor Todd explained.

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Syed Arif Ahmed, MD
Action, Date Taken: Summarily Suspended, May 17, 1989.
Reason: Drug Related

Name: Manuel A. Alfonso, MD
Action, Date Taken: Suspended, November 16, 1988.
Reason: Unethical Business Practice

Name: Arthur S. Lightfoot, MD
Action, Date Taken: Suspended – two years, January 30, 1989.
Reason: Negligency/Incompetency

Name: Donald L. Lipsey, MD
Action, Date Taken: Voluntary Surrender, April 19, 1989.
Reason: Mental/Physical Incompetency

Name: Roger A. Mattson, MD
Action, Date Taken: Reprimand; fined $250, probation indefinite, March 17, 1989.
Reason: Drug related

Name: Richard Allen Patyk, MD
Action, Date Taken: Summarily Suspended, April 19, 1989.
Reason: Negligence – Incompetency

Name: Jose M. Tombo, MD
Action, Date Taken: Revoked, April 19, 1989
Reason: Immoral Conduct

Name: Robert W. Wyman, MD
Action, Date Taken: Reprimand; fined $250, probation – two years, March 15, 1989.
Reason: Mental/Physical Incompetency

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1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2 For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states

3 The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

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Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient

Laboratory Tests: Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics, see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the OT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest

Treatment measures for hyperkalemia include the following:

1 Elimination of foods and medications containing potassium and of potassium-sparing diuretics

2 Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3 Correction of acidosis, if present, with intravenous sodium bicarbonate.

4 Use of exchange resins, hemodialysis, or peritoneal dialysis

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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- ☐ recognize the clinical symptoms of abuse/neglect and distinguish abuse/neglect from normal aging
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- ☐ clarify case management techniques for elderly victims of abuse/neglect and identify agencies and services for referral

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AMA Reports Available From MSMS

The following reports were considered at the AMA House of Delegates Annual Meeting in Chicago, June 18-22, 1989. Copies are available by contacting Sherry Wellman, MSMS Department of Communications & Professional Relations, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351.

Board of Trustees

Report H — Drug Abuse in the United States: Strategies for Prevention

Report L — Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

Report V — Study of the Canadian Health Care System

Report BB — Implication for Physicians in Hospitals that Contract with Alternative Delivery Systems

Report CC — Guidance for HIV-infected Health Care Workers in Their Professional Duties

Report FF — Hospital Medical Staff and Joint Venture Oversight Committees

Report NN — Physician Payment Under Medicare: Resource-Based Relative Value Scale for Physician Services

Report OO — Living Wills, Durable Powers of Attorney and Durable Powers of Attorney for Health Care

Report PP — Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy

Report QQ — Medical Ethics

Report SS — Medical Expert Witness Qualifications

Report AAA — Strengthening the US Health Care System

Report EEE — Expenditure Targets Under Medicare

Council on Long Range Planning and Developing

Report B — Implications of Trends in Physician and Public Attitudes

Council on Medical Education

Report B — Principles for Graduate Medical Education

Report D — Assessing the Impact of AIDS on Residency Training

Council on Medical Service

Report C — Misleading Explanation of Benefits Language

Report E — Patient Satisfaction and Quality of Care

Report G — Rural Health Care

Report N — Indigent Health Care

Council on Scientific Affairs

Report B — Impact of US Tobacco Exports on Worldwide Smoking Epidemic

Report C — Health Status of Detained and Incarcerated Youth

Report D — Atherogenic Agents in Food Products

Report E — Global Climate Change: The "Greenhouse Effect"

Report F — Mammographic Criteria for Surgical Biopsy of Nonpalpable Breast Lesions

Council on Scientific Affairs Council on Ethical and Judicial Affairs (Joint Reports)

— Medical Applications of Fetal Tissue Transplantation

— Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support

— Recognition of Childhood Sexual Abuse as a Factor in Adolescent Health Issues

— Health Effects of Video Display Terminals: An Update

— Geriatric Health White Paper

— Home Care: A Definition

— Health Education: Its Efficacy and Status in Primary Care

Also available is a report detailing AMA House of Delegates action on the following 10 resolutions introduced by the Michigan Delegation:

Resolution #143 — "Lapel Pin for AMA Membership"

Resolution #144 — "Graduates of Foreign Medical Schools Involvement in the AMA"

Resolution #145 — "Terminology Used by Fiscal Intermediary (Medicare Carrier) on Medicare Voucher"

Resolution #146 — "Opposition to the Use of Infant Walkers"

Resolution #147 — "Durable Medical Goods"

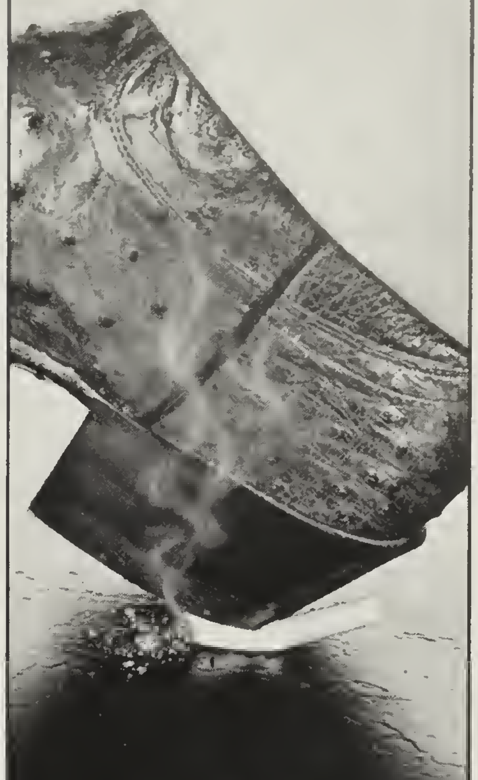
Resolution #148 — "Ban the Sale & Ownership of Assault Rifles Originally Designed Primarily for Human Destruction"

Resolution #149 — "Financial Aid and Loans"

Resolution #150 — "National Beverage Container Reuse & Recycling Program"

Resolution #151 — "Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes"

Resolution #152 — "Anabolic Steroid Abuse" ■



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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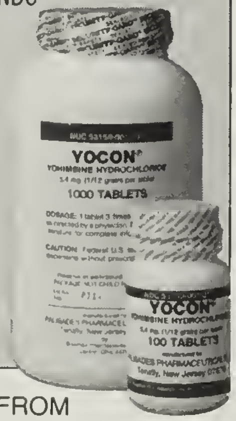

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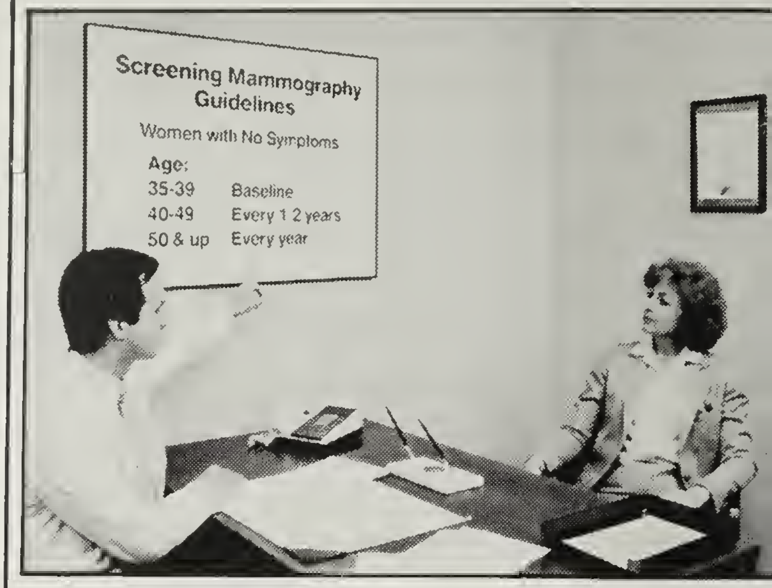

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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36300 Van Dyke
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Sang Hwi Choi, MD — GS
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Jeffrey A. Keenan, MD — OBG
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Paul S. Kenyon, MD — ORS
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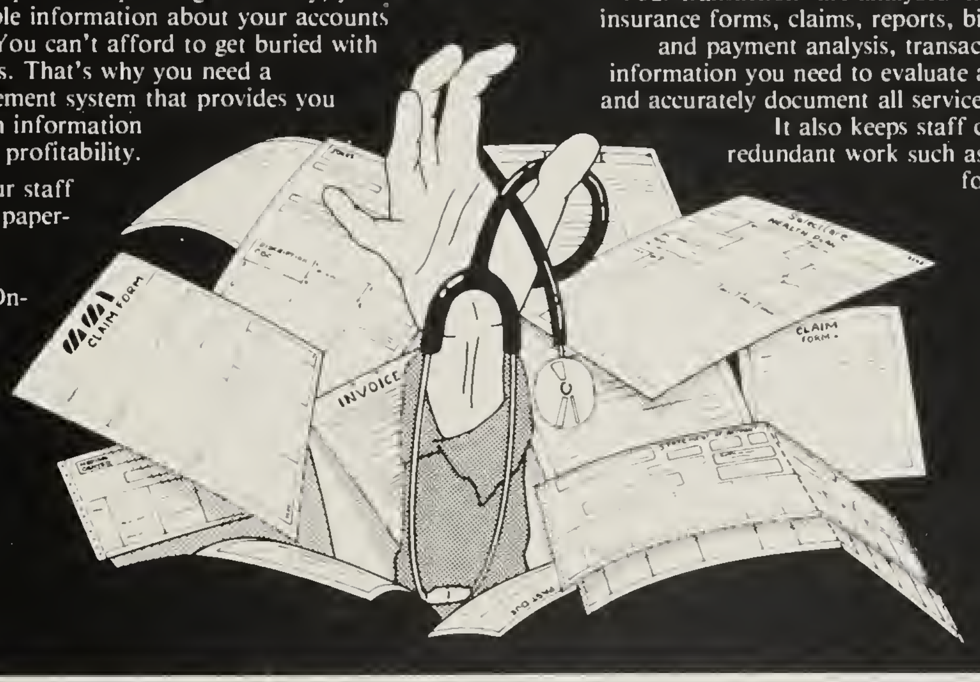

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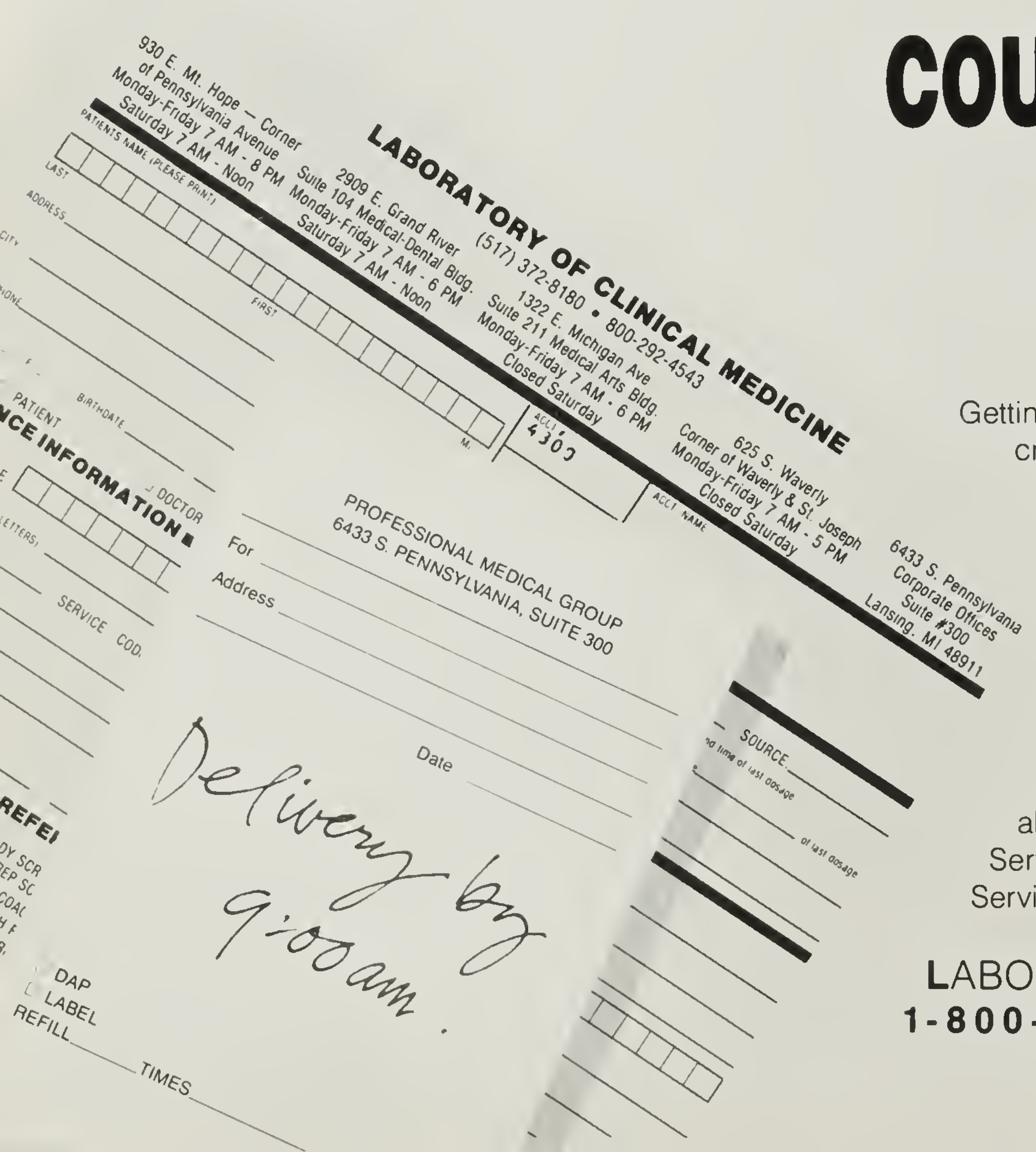

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MEETINGS

MSMS Meetings

September

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

26, MSMS Public Affairs/Leadership Conference, Lansing Radisson, Lansing, Michigan, Contact: Mary Anne Ford, MSMS Chief, State Government Affairs, (517) 337-1351.

28, 1989 CME Conference, Hilton Inn, Lansing, Michigan, Contact: Katie Brewbaker, MSMS Chief, Support Services, (517) 337-1351.

AMA Meetings

October

2-3, Eighth Annual AMA Science Reporters Conference, Marriott Medical Center Hotel, Houston, Texas, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-4417.

Michigan Specialty Society Meetings

July

31-8/2, Michigan Academy of Family Physicians, 43rd Annual Scientific Assembly, Grand Traverse Resort, Acme, Contact: Julie Nelson, 109 East Oakland, Lansing, MI 48906 (517) 482-7410.

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076 (313) 557-8633.

National Specialty Society Meetings

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601 (312) 644-6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology.

11-15, American College of Allergy and Immunology, Orlando, FL, Contact: American College of Allergy and Immunology, 800 E. Northwest Highway #1080, Palatine, IL 6006 (312) 359-2800.

13-16, American Heart Association, New Orleans, LA, Contact: American Heart Association, 7320 Greenville Avenue, Dallas, TX 75231 (214) 706-1483.

December

2-5, American Society of Hematology, Atlanta, GA, Contact: American Society of Hematology, 6900 Grove Road, Thorofare, NJ 08086 (609) 845-0003.

2-7, American Academy of Dermatology Annual Meeting, San Francisco, CA, Contact: American Academy of Dermatology, 1567 Maple Avenue, P. O. Box 3116, Evanston, IL 60204-3116 (312) 869-3954.

Other Meetings

September

11-13, Treatment of Destructive Behaviors in Persons with Developmental Disabilities, Warren Grant Magnuson Clinical Center, Bethesda, Maryland. Rockville pike, Rockville, Maryland 20852. (301) 468-6555.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact: American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114 (816) 333-9700.

21-23, American College of Nuclear Medicine Scientific Meeting, Swiss Grand, Chicago, IL. Contact: American College of Nuclear Medicine, Box 5887, Columbus, GA 31906 (404) 322-8049.

21-24, American College of Nuclear Physicians Interim Meeting, Loews L'Enfant Plaza Hotel, Washington, DC. Contact: American College of Nuclear Physicians, 1101 Connecticut Ave., NW, Ste. 700, Washington, DC 20036 (202) 857-1135.

24-27, American Neurological Association, New Orleans, Contact: American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414 (612) 378-3290.

24-28, American Academy of Otolaryngology — Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology — Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005 (202) 239-4607.

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016 (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312) 825-5586.

15-20, American College of Surgeons Annual Scientific Meeting, Atlanta Hilton and Towers, Atlanta, GA, Contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312) 664-4050.

19-22, American Society of Internal Medicine Annual Meeting, J.W. Marriott, Washington, DC, Contact: American Society of Internal Medicine, 1101 Vermont Avenue, N.W., Suite 500, Washington, DC 20005 (202) 289-1700.

21-25, American College of Gastroenterology Scientific Meeting, Marriott Hotel, New Orleans, LA, Contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

21-26, American Academy of Pediatrics Annual Meeting, Chicago, IL, Contact: American Academy of Pediatrics, 141 Northwest Point Road, P. O. Box 927, Elk Grove Village, IL 60007 (312) 288-5005.

23-25, American College of Gastroenterology Annual Meeting, Marriott Hotel, New Orleans, LA. Contact: American College of Gastroenterology, 13 Elm St., Manchester, MA 01944 (617) 927-8330.

28-11/3, American Society of Clinical Pathologists Annual Scientific Meeting, Ramada Renissiance, Washington, DC, Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612 (312) 738-1336.

28-11/3, College of American Pathologists Annual Scientific Meeting, Washington Ramada, Washington, DC, Contact: College of American Pathologists, 5202 Old Orchard Road, Skokie, IL 60077. (312) 966-5700.

29-11/2, American Academy of Ophthalmology Annual Meeting, Convention Center, New Orleans, LA, Contact: American Academy of Ophthalmology, P. O. Box 7424, 655 Beach, San Francisco, CA 94120. (415) 561-8500.

29-11/3, American Society of Plastic and Reconstructive Surgeons Annual Scientific Meeting, San Francisco Hilton, San Francisco, CA. Contact: American Society of Plastic and Reconstructive Surgeons, 233 N. Michigan Ave., Suite 1900, Chicago, IL 60601 (312) 856-1818.

29-11/4, Congress of Neurological Surgeons Annual Meeting, Atlanta, GA, Contact: Congress of Neurological Surgeons, University of Southern California, 1200 N. State Street, Los Angeles, CA 90033 (213) 226-7421.

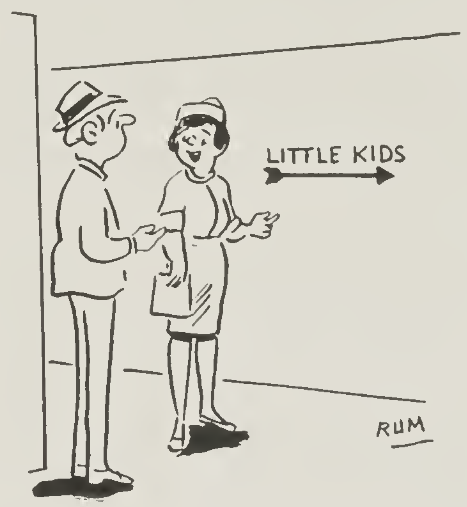
30-11/3, American College of Chest Physicians, Annual Meeting, Sheraton/Weston, Boston MA. Contact: American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068 (312) 698-2200.

30-11/3, American Academy of Occupational Medicine Interim Meeting, Sheraton Inner Harbor, Baltimore, MD, Contact: American Academy of Occupational Medicine, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

November

3-4, American Academy of Pain Medicine, 1989 Annual Conference, Dallas, TX, Contact: American Academy of Pain Medicine, 43 East Ohio #914, Chicago, IL 60611 (312) 645-0083.

5-10, American Academy of Physical Medicine and Rehabilitation, Convention Center, San Antonio, TX, Contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603-6107 (312) 922-9366.



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July

19, Risk Management Seminar. Location: Ramada Inn, Marquette, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351.

20-21, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386 (616) 922-9546. **Approved for:** 9-13 hours Category I Credit.

23-26, 3rd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (31) 763-1400. **Approved for:** 13 hours Category I Credit.

27, Risk Management Seminar. Location: Bay Valley, Bay City, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351. **Approved for:** 4 hours Category I Credit.

27-28, Management of Orthopaedic Problems: Comparing British & American Techniques. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton CME/Program Assistant, 2799 W. Grand Blvd., Detroit, MI 48202-2689 (313) 876-3073. **Approved for:** 12 hours Category I Credit.

August

4-5, Endoscopic Sinus Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

6-9, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

7-9, Airborne Pollen and Fungus Spore Identification: A Hands-On Workshop. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 17 hours Category I Credit.

9, Risk Management Seminar. Location: Wayne County Medical Society, Detroit, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351. **Approved for:** 10 hours Category I Credit.

18-21, Cardiology Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

24-26, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort Village, Grand Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

25-27, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

September

7-8, The Practice of Clinical Nutrition: Science & Application for the Future. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763- 1400. **Approved for:** 10 hours Category I Credit.

11-12, Epilepsy Advances. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

13, Update: Medical Management & Treatment of Arthridities. Location: Southfield Hotel & Conference Center. **Contact:** Shelley L. Helton, CME/Program Assistant. Henry Ford Hospital Office of Medical Education, 2799 W. Grand Blvd., Detroit,

CATEGORY I COURSES

Michigan 48202-2689 (313) 876-3073. **Approved for:** 4 hours Category I Credit.

14-16, Recent Trends in Clinical Electrophysiology: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

21-23, The National Conference on Pediatric Trauma. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** Kiqanis Pediatric Trauma Institute, New England Medical Center, University of Michigan Medical School, General Motors Corp., **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

21-24, 34th Annual ACP-Michigan Chapter/MSIM Regional Meeting. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** American College of Physicians, Michigan Chapter and the Michigan Society of Internal Medicine. **Contact:** Patrick C. Alguire, MD, FACP, Department of Medicine, Michigan State University, B-301 Clinical Center, East Lansing, MI 48824. (517) 353-5100. **Approved for:** 18.5 hours Category I Credit.

28-30, Advanced Concepts in Total Hip & Total Knee Revision Surgery. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, CME/Program Assistant, Office of Medical Education, 2799 W. Grand Blvd., Detroit, Michigan 48202-2689 (313) 876-3073. **Approved for:** 16 hours Category I Credit.

October

2-3, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

4-6, A Symposium on Neonatal Respiratory Disorders. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

5-7, 12th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 16 hours Category I Credit.

12-14, 20th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids, Michigan. **Sponsors:** MSU College of Human Medicine, International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Bldg., 1900 Wealthy S.E., Suite #290, Grand Rapids, MI 49506 (616) 774-0440. **Approved for:** 18 hours Category I Credit.

18, Pediatric Urology for the Practitioner. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial and Behavioral Issues. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. **Approved for:** 13 hours Category I Credit.

25-28, Midwest Addictions Conference. Location: Detroit Radisson Hotel, Detroit Airport. **Sponsors:** Samaritan Health Center, American Medical Society on Alcoholism and Other Drug Dependencies, Western Michigan Addictionology Consultants, Inc., Michigan Psychological Association. **Contact:** Diane Campbell, Samaritan Health Center, 5555 Conner Ave., Detroit, MI 48213 (313) 579-4925. **Approved for:** 26 hours Category I Credit.

November

13-14, 8th Annual Michigan Statewide Conference on Child Abuse and Neglect: Child Abuse and Substance Abuse. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, University of Michigan Child Protection Team. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

NOTICE

EMERGENCY WASTE MANAGEMENT rules went into effect June 12, 1989 for all medical offices and laboratories in the State of Michigan.

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FAMILY PRACTICE — HOSPITAL-SPONSORED clinic opportunity. Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking two family physicians for a new clinic facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus, and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, President, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, MN 55435 (612) 835-5123.

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ORTHOPEDIC SURGEONS - Wisconsin: Marshfield Clinic, a multispecialty group practice with over 300 physicians, is seeking BE/BC orthopedic surgeons to join expanding regional centers. Positions available in two locations; one in northwestern Wisconsin within 90 miles of Minneapolis and one, a group practice of 25 physicians, in north central Wisconsin approximately 1 1/2 hours from Lake Superior. Communities offer exceptional recreational, cultural, and educational opportunities. Compensation package with starting salary up to $149,100 combined with outstanding fringe benefit package totals in excess of $200,000. There is no buy-in or start-up expense. Send CV and references to: David L. Draves, Director Regional Development, 1000 North Oak Av-

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Five Steps to Unity

By Robert E. Paxton, MD

After glancing at the title of this article you may be thinking, "Please, no more rhetoric on unity!" As you voice your displeasure and prepare to turn the page, wait a few moments and read on.

I am fully aware that we constantly hear the call for unity from the lecterns of our medical leadership. We read about it in most medical editorials and socio-economic articles. But what exactly is involved in this call for unity? I feel the subject is so important that I ask you to follow me as I try to walk you step-by-step through the "how to" rather than the "need to" of unity.

Step one

Step one is to recognize the differences that do exist in our profession. We are in different specialties which deal with different mixes of cognitive and procedural activity. This, in turn, varies the reimbursement according to fee schedules. These are varying degrees of risk and severity of services undertaken by different specialties. Demographics and geography have a profound effect on variances as well as different time demands.

Competition has accentuated differences that are evident in minorities and graduates of foreign medical schools. Cost containment activity and alternative health care delivery systems have created friction and animosity, such as is seen with the gatekeeper concept. Professional liability premium costs aggrevate the low-risk physicians when they have to help subsidize the high-risk practitioner. I could go on, but the list of differences is endless.

The first step becomes painfully obvious. I can only reiterate the axiom: Our diversity gives us depth; our unity gives us strength!

Step two

Step two is to recognize that with the complexity of differences within the profession, we must be reasonable in all of our reactions. Regardless of our specialty or area of practice, we must understand each others position and work together to learn the facts. We must be trustworthy and maintain integrity so that we can demonstrate that physicians can unify and accomplish that which is good and in the best interest of the public. This approach is mandatory.

Step three

Before you become demoralized or discouraged with the prospect of what lies ahead, let me quickly review what has already taken place.

The AMA House of Delegates, representing all specialties, geographic localities and kinds of physicians, wrestled with the problem of unity created by the RBRVS. After hours and, in fact, days of discussion and debate in Texas last December, a concensus was unanimously adopted which clearly stated AMA policy on a very divisive issue.

In Michigan, we are revitalizing and increasing the activity of the Committee of Specialty Society Presidents.

One additional example is the historic formation of the MSMS Section for Graduates of Foreign Medical Schools — the first of its kind in the nation.

These few examples illustrate that we can successfully deal with unity, but please do not get complacent. Let's move on to the next step.

Step four

Let us do a little honest self-assessment and evaluation. How do we personally react to certain problems that evolve from our diversity?

The Physician Payment Review Commission from the Subcommittee on Ways and Means has recommended expenditure targets — literally caps that place the physician in the role of one who rations care. How do we react when our specialty society — the American College of Surgeons — tries to cut a special deal and accept this concept? Or, what do we say to our leadership of the American College of Radiology when they publically support one of our chief antagonists — Rep. Pete Stark — as he strikes against doctors over the divisive concept of physician ownership of labs and facilities?

Perhaps the most serious problems develop because of turf battles. Tension mounts from personal reactions to reimbursement schemes and gatekeeper concepts. I could elaborate, but the threat to unity is obvious and our personal commitment is essential.

Step five

The fifth step is perhaps the most important one. We must realize that there is much more to unite us than to divide us. The motivation for unity is strong. That motivation is precipitated by the health care planners in government and industry; planners who, for the most part, are economists who do not regard health care as a priority; manipulators who limit benefits to meet insufficient resources; activists who proceed to structure the system so the provider is responsible for rationing care. Furthermore, they fully realize that they will never get these ideas established if there is a strong united offensive from providers. The Solution: Get the providers to fight among themselves and the rest is easy.

To fight these trends and develop innovative answers to our nation's health problems, unity is the key word. I believe we are capable of that kind of unity. Mass movements begin with individual attitudes and changes in perceptions.

The next time the hair bristles on your neck because of a difference with a colleague, remember the need to remain united! ■

Doctor Paxton is MSMS president.

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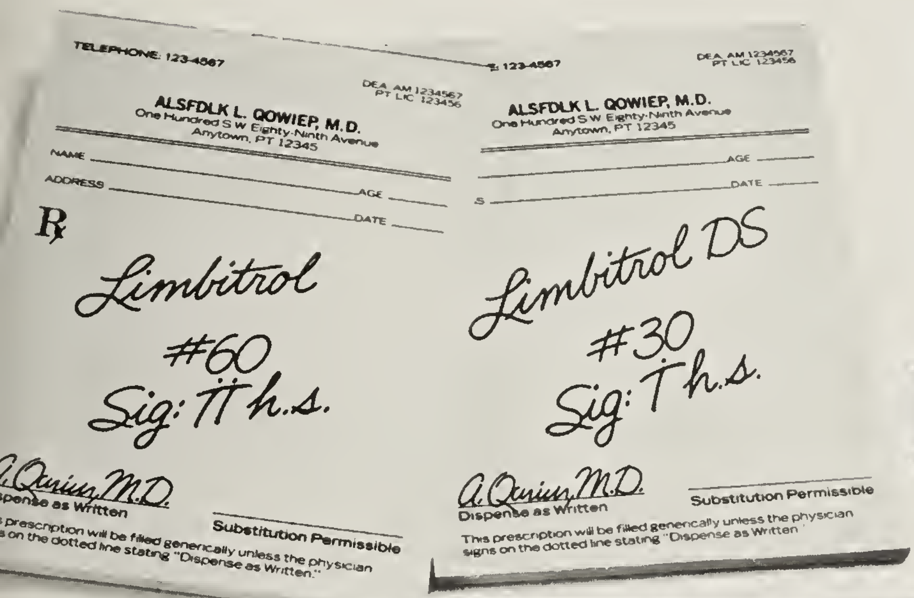
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively.
I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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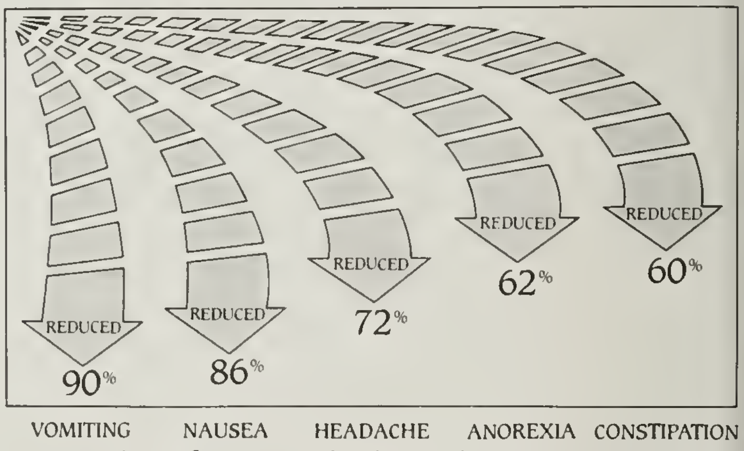

*Patients often presented with more than one somatic symptom.

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Limbitrol® DS

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Please see summary of product information inside back cover.

MICHIGAN MEDICINE

GUST 1989
.. 88, NO. 8

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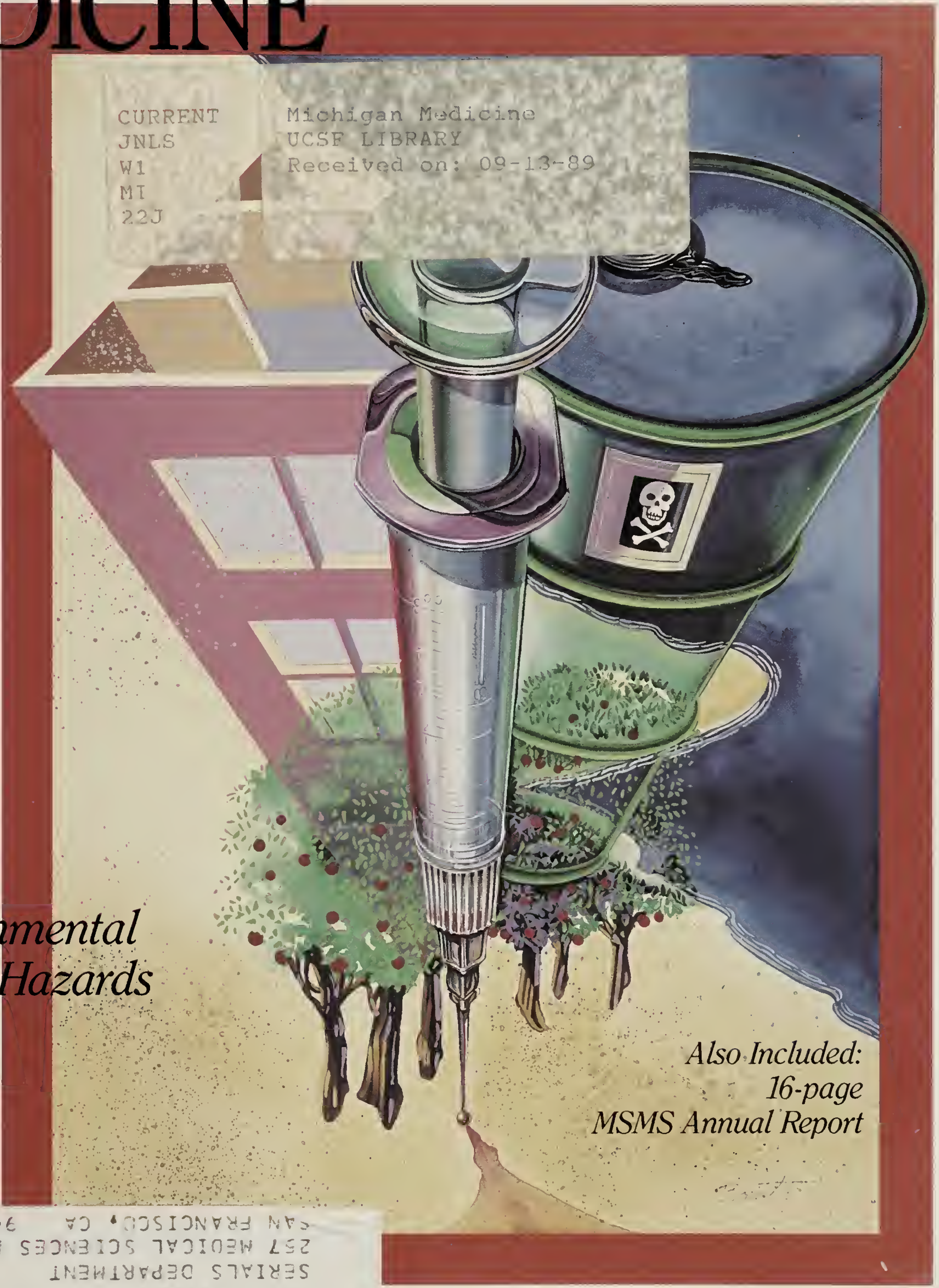

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MICHIGAN
MEDICINE

Award-Winning Journal of the Michigan State Medical Society

AUGUST 1989
VOL. 88, NO. 8

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Cover Story

Environmental Health Hazards — Michiganians have been exposed to their share of them lately. For example, in Freeland recently, a train carrying chemicals derailed and burned, forcing 1,000 local residents from their homes for days to escape toxic fumes. MSMS members increasingly are focusing their attentions on the environment. Because of this closer scrutiny by MSMS members, both collectively and individually, environmental health hazards are the subject of this month's cover story. Included in the cover story are articles on medical waste problems, on hazards of indoor air pollution, and on safeguarding our lands and waters from radioactive waste pollution. Wrapping up the cover story is a sidebar which details one Michigan physician's efforts to reforest our country, thereby restoring natural resources and improving air quality.

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In next month's issue of *Michigan Medicine*: Risk Prevention.

Cover illustration by: *Robert L. Brent.*

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Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done Part of the dose of nizatidine is metabolized in the liver In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects

CNS — Rare cases of reversible mental confusion have been reported

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients Rash and exfoliative dermatitis were also reported

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

[1] Data on file, Lilly Research Laboratories.

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IN MY OPINION

Physicians Need to Know More About Environmental Health Risks

By Kenneth Rowe, MD

The members of the MSMS Committee on Publications invite Michigan Medicine readers to submit editorials for publication on this page.

Unless you are an occupational health physician or perhaps an infectious disease doctor, you may not give much thought about how the environment affects your patients.

While water-borne infections were once a common problem, public health sanitation measures have essentially eliminated the problem. In its place we now have concerns with volatile organic chemicals, nitrates, insecticides, and pesticides in the groundwater. The alert practicing physician needs to consider such problems in dealing with the difficult case that defies usual diagnostic evaluation.

What do you know about possible carcinogens in food and water? How do you interpret environmental risk to patients who ask about radon and asbestos or formaldehyde in their home or school?

Interpretation of the risk of consuming parts per billion of DDT, PCB, Mercury and Chlordane as a negative effect on health needs to be weighed against the benefits of eating fish on cardiovascular disease. Are you and your patients confused about the many advisories and warnings? Many people are.

The Michigan Department of Public Health can provide you with information which can help you advise your patients (and yourself if you are a consuming sports fisherman).

These are just a few examples of some of the environmental concerns receiving increasing attention by the media and the public.

In my opinion, there is a need for the practicing physician to know more about environmental risk assessment, risk management, and risk communication as we try to assist our patients to grow up and live healthy.

Doctor Rowe is director of the Western Upper Peninsula District Health Department and, until recently, served as chief medical executive of the Michigan Department of Public Health.

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Letters from Our Readers

MSMS President Paxton's emphasis on unity supported

We read with interest the article on Robert E. Paxton, MD, in the June 1989 issue of *Michigan Medicine* regarding his installation as president of the Michigan State Medical Society. We admire Doctor Paxton and hold him in very high regard.

We agree with Doctor Paxton's suggestion that those of us in the medical care field must maintain a positive, upbeat attitude despite the current threats to health care. It is our feeling that medical care must regain its collaborative approach and move away from adversarial relationships which have been forced upon us by insurance carriers, lawyers, and the Government. This adversarial relationship has now extended to our patients, and we believe there are actions that can be taken to alleviate these problems.

Patients respond to competence of the professional, a caring attitude, and frank communication. Patient education and patient communication have lagged far behind the evolution of high-tech medical care. Not only must physicians speak individually to their patients, their communication also must be part of an overall patient education system — one that incorporates other health care providers to include health insurers and the Government.

Through a structured process of patient education and communication, the adversarial atmosphere in which we currently find ourselves will be changed to a collaborative one. This will enhance patient care and patient compliance, allowing patients to participate in their medical care as informed individuals; they then can accept responsibility for their medical care decisions as a knowledgeable member of the health care team.

These factors will lead not only to happier patients and health care providers, but also will lead to dramatic cost savings. We only need look at the current cost of "defensive medicine" to understand the full ramifications of adversarial relationships in health care. If we allow ourselves to continue under the burden of an adversarial mode in health care, it will lead to a collapse of availability and quality with escalating costs. We support Doctor Paxton's positive approach to seek solutions.

Collaboration, based upon a structured educational process, will enhance communication and, importantly, is the way of the 1990s. Thank you for your attention and consideration of the above.

Oliver D. Grin, Jr., MD, FACS
Dorothy W. Bouwman, RN, MSN
Grand Rapids

Article on Michigan Society of Medical Assistants praised

Congratulations to you and your reporter Chad Munger on the article about the Michigan Society of Medical Assistants (June '89 *Michigan Medicine*, page 41).

In addition to a very active MSMA, many of the group's members also serve significant positions with the American Association of Medical Assistants. Two members serve on the Curriculum Review Board, the accrediting body of AAMA — one with the Continuing Education Board and one as vice chairman of the Certifying Board. Many of the educator members of MSMA serve as site visitors for post-secondary institutions seeking accreditation.

Thank you again for your recognition of this "important resource" for today's medical practice.

Alice Covell, CMA-A
Kalamazoo

More on worker's comp rules

Upon review of the letters in *Michigan Medicine*, (Volume 88, No. 5, May, 1989), of Doctors Dorsey ("Read new Workers' Compensation rules carefully"), and Villa ("Physicians are becoming unpaid employees of insurance companies"), and the recent *Medigram* (Volume 5, June 6, 1989) report of Doctor Paxton requesting delay in the workers' compensation fee schedule implementation, physicians now have firm documentation as to legislative intent in *ipso facto* insurance carrier mediated and mandated "managed healthcare" intervention. Therefore, the premise underlying the Wickline decision in California requiring *physician advocacy* to *challenge third party payors* (even Medicare) as an unwarranted intrusion into the medical care decision process, hospital discharge, et cetera, is reemphasized.

As physicians, we are advocates of our patients. We must (return) to seeking and obtaining appropriate treatment for our patients, even if this requires our personal representation in courts to expedite a judicious medical (versus administrative, managerial or politically economic) decision.

I encourage Doctors Dorsey and Villa, and Doctor Paxton's representatives to the Office of Health & Medical Affairs of the State (Doctors Jacknow and Margulies) to stand up to the challenge of these intrusions and not withdraw from their patients' care and advocacy.

S.E. Newman, MD
Detroit Institute
of Physical Medicine and
Rehabilitation

A call for membership

Physicians for Research in Cost-Efficiency (PRICE) is a new organization designed to meet the challenge of the turbulent times ahead for those of us in health care.

I am asking you to become a member of PRICE. The goal of the organization is to facilitate communication about low-cost quality medical information between physicians involved in research, academics, administration, and practice. A newsletter will provide information on research efforts, political trends, and, most important, clinical observations and practice innovations for the practice of cost-effective medicine. In addition, PRICE will serve as a clearinghouse for conferences, new job opportunities, and training options for physicians interested in cost issues in medicine.

Interested physicians can gain membership by submitting a letter of interest and a curriculum vitae. There are no fees and no financial sponsors. Please address correspondence to me: David J. Shulkin, MD, president, PRICE, 926 Bellefonte St., Pittsburgh, PA 15232; or call (412) 682-8015.

David J. Shulkin, MD
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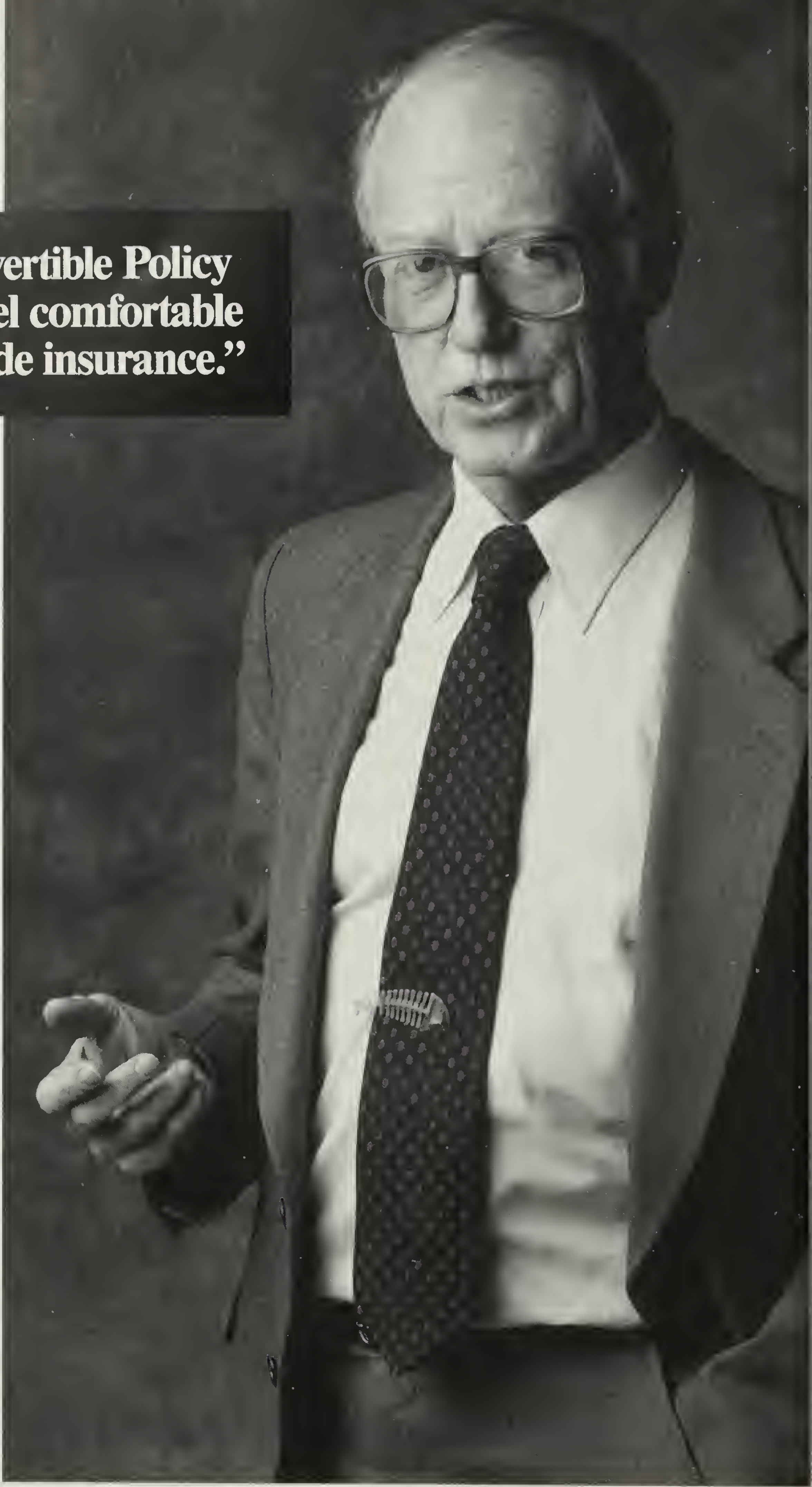

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Two U-M studies show promise for treatment of heart, vascular disease

Two experiments using genetically modified cells to line blood vessels may improve treatment of vascular disease, University of Michigan medical researchers announced June 15.

Two recent reports describe the successful attachment of genetically modified endothelial cells to blood vessels in animals. Both studies hold some promise for treating cardiovascular disease in humans, said Gary Nabel, MD, PhD, U-M assistant professor of internal medicine and biological chemistry and a Howard Hughes Medical Institute researcher.

Endothelial cells naturally line the inside of blood vessels. One study reports the successful implantation of synthetic vascular grafts with genetically modified versions of such cells.

The other article details stable implantation of similarly modified cells directly onto artery walls with a specially designed arterial catheter.

According to Doctor Nabel, "In theory, this work may not only prove to be useful for heart disease and other circulatory disorders but it also may be possible to use these cells to secrete therapeutic proteins directly into the blood. It may have application to the management of cardiovascular disease in several ways, for example by introducing cells modified to release thrombolytic (anti-clotting agents), to induce the formation of new blood vessels, or to dilate blood vessels."

Doctor Nabel co-authored this paper along with four other U-M Medical Center faculty: Elizabeth Nabel, MD, assistant professor of internal medicine; Gregory Plautz, MD, a post-doctoral fellow; Frederick Boyce, MD, PhD, a U-M graduate; and James Stanley, MD, professor of surgery and head of the section of vascular surgery.

New drugs may treat schizophrenia, cocaine addiction

Why would a person who regularly uses stimulants, such as amphetamines, Ritalin or cocaine, develop symptoms resembling paranoid schizophrenia?

Why do drugs that block the brain chemical transmitter, dopamine, help to treat certain schizophrenic symptoms?

Why does bromocryptine limit the craving of a cocaine addict without providing the euphoria?

Why does the drug L-Dopa, which helps the sufferers of Parkinson's disease, also produce unwanted side-effects?

These clinical observations and others have spawned the science of neurobiology, the study of brain structure and function, said neuroscientist Louis Chiodo, PhD, chief, Laboratory of Neurophysiology, Sinai Hospital Research Institute, Detroit.

Doctor Chiodo recently received a five-year renewal grant of almost $800,000 from the National Institutes of Mental Health to answer these questions and others by exploring the brain's basic structure — the nerve cell or neuron. Specifically, he is studying those neurons responsible for producing and transmitting the neurochemical, dopamine.

"Psychiatry is moving away from strictly cognitive and therapeutic approaches to the biological," Doctor Chiodo says. He believes that his laboratory work and that of his colleagues around the country will eventually lead to more effective drugs with fewer side effects to treat various neuropsychiatric disorders in man.

Probing the electrical activity of dopamine neurons, Doctor Chiodo expects to determine how they work, what regulates their activity and their response to dopamine and to dopamine agonists. "We want to know what makes them tick."

Doctor Chiodo's work has led him to hypothesize that "the hard wiring of the brain determines its response to stimulants." That awareness inspired his speculation that "some people may be predisposed to develop schizophrenia by their basic wiring."

Determining the structure and function of dopamine neurons and their response to various chemicals may someday provide a way to predict and thwart behavioral disorders.

Already, the Sinai lab has reported discovery of differential regulation of unknown sub-groups of dopamine neurons.

The time to worry about adult health begins in childhood, MDPH report says

Heart disease, strokes, cancer and even physical injuries are rooted in childhood health and safety habits, according to a Michigan Department of Public Health report prepared jointly by experts from The University of Michigan, Michigan State University, and the Michigan Cancer Foundation.

The report urges state policy-makers to take a broad range of actions now to improve the health of Michigan's future adults.

"Cardiovascular disease, cancer and injuries account for more than 80 percent of deaths for persons age 25 and older, and more than 60 percent of the potential life years lost in Michigan," explains Lewis H. Margolis, assistant professor of public health policy and administration at the U-M School of Public Health.

"But exposure to the causes of disease and injury — alcohol, tobacco, fatty foods, lack of exercise, failure to use seat belts, use of handguns and so on — begins in childhood and adolescence. If we start now to control this exposure, we should have a measurable impact on the health of Michigan citizens by the year 2010," he says.

Co-authors of the report, "Growing into Healthy Adults: The Pediatric Antecedents of Adult Disease," include Albert W. Sparrow, professor of pediatrics and human development at Michigan State

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University, and G. Marie Swanson, vice president for epidemiology and director of biostatistics, Michigan Cancer Foundation.

The report recommends that state policy-makers:

■ Enforce laws prohibiting the sale of cigarettes and alcohol to minors. "We should ban cigarette vending machines altogether and crack down on merchants who sell cigarettes and alcohol to minors. In communities where this has been done, it has been very effective," Margolis says.

■ Raise the price of cigarettes and alcohol by increasing excise taxes. "High prices will make it harder for young people to buy," Margolis observes. "We also recommend that the extra excise taxes be earmarked for alcohol control programs."

■ Ban smoking in any public area frequented by children or adolescents. "Such a law would affect shopping malls and restaurants — fast food restaurants, in particular," Margolis says.

■ Set up strict rehabilitation programs for adolescents charged with drinking and driving.

■ Require cigarette companies to manufacture cigarettes that extinguish themselves. "The technology exists to do this, and such a move would cut the number of house fires in half," Margolis says.

■ Offer special insurance benefits to low-risk individuals.

■ Offer financial incentives to school districts and fast food chains that offer low-fat, low-salt breakfasts and lunches.

■ Enforce environmental regulations dealing with carcinogenic pollutants and pesticides. "Children are generally more susceptible to toxic agents than adults," Margolis notes.

■ Regulate handguns. "Handguns are creating an epidemic of deaths among young Black males, in particular," Margolis says.

■ Mount health education and cardiovascular fitness campaigns in grades K-12.

According to Margolis, significant percentages of the state's youth are at risk for cardiovascular disease, cancer and serious injury. By age 18, he says, about 28 percent of the young men and 32 percent of the young women in the state smoke. Also about 74 percent of the men and 64 percent of the women drink alcohol by age 18.

Between 10 and 20 percent of all Michigan children under age 18 are at risk for high cholesterol levels, and 10 percent of the males are at risk for high blood pressure, Margolis notes. "And studies estimate that 13 percent to 24 percent of the boys and 13 percent of the girls are obese. Also, 50 percent of both sexes between ages 16 and 29 fail to use seat belts consistently.

"Clearly, the risk factors are pervasive. However, they are amenable to change if the state and its citizens choose to act," Margolis says.

GDAHC receives grant for AIDS program

The Greater Detroit Area Health Council, Inc. (GDAHC) has received a one-year grant in the amount of $33,000 from the Ford Motor Company Fund in support of the Coordinated Community AIDS Program (C-CAP) for Southeastern Michigan.

C-CAP is a community-wide effort to deal with the tremendous economic and social costs of the AIDS epidemic. It is sponsored by GDAHC and United Community Services of Metropolitan Detroit, with close support from the eight local health departments in southeastern Michigan. More than 60 other organizations including many hospitals and social service agencies are also participants in the program. With this grant, the Ford Motor Company Fund joins a funding coalition which includes the McGregor Fund, the W.K. Kellogg Foundation, the Michigan Department of Public Health, the United Way,

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Physicians in the News

Howard V. Dubin, MD, Ann Arbor, is the newly-elected secretary/treasurer of the Dermatology Foundation. The Foundation is the major national fund raising organization for research in cancer and other diseases of the skin. Doctor Dubin is clinical professor in the Department of Dermatology at the University of Michigan Medical School and has a private practice in Ann Arbor. He is former president of the Michigan Dermatological Society, and has been on the Executive Committee of the Dermatology Foundation since 1987.

Karl Kristen, MD, is the new medical director of Mount Carmel Mercy Hospital's Department of Radiology and Nuclear Medicine. Doctor Kristen graduated from the Wayne State University School of Medicine and served his internship at the Detroit Receiving Hospital. He has been a department radiologist at Mt. Carmel since 1966 and has been instrumental in the development of the Nuclear Medicine service, the CT Scanner program, and the shared Magnetic Resonance Imager consortium.

Joseph Cools, MD, has been named director of Psychiatric Services at Marquette General Hospital. Doctor Cools will oversee development of upgraded mental health services at the regional medical facility, an important facet of the hospital's $34 million expansion project. He came to Marquette General Hospital from Duke University Medical Center in North Carolina, where he was director of Psychiatric Rehabilitation Services.

Charles B. Wolf, MD, is the new president of the Metropolitan Pediatric Society, Detroit Chapter. Doctor Wolf has been an active member of the Society for more than 23 years and for the past four years, he has been a member of the Society's Executive Board. He also is editor of the American Academy of

Pediatrics Newsletter, Michigan Chapter. Currently a senior staff pediatrician at Henry Ford Medical Center, West Bloomfield, Doctor Wolf has been with Henry Ford Hospital and Medical Centers for 24 years and was the original medical director of the West Bloomfield center when it opened in 1975. He specializes in the growth problems of children.

James Breneman, MD, a Galesburg allergist, recently lectured at the American In-Vitro Allergy and Immunology Society's annual meeting in San Diego, California. Doctor Breneman lectured on "Food Allergy and New Diagnostic Methods." He is board certified in allergy and immunology.

Bruce M. Gans, MD, is the new president and chief executive officer of the Rehabilitation Institute in Detroit, chairman of the Department of Physical Medicine and Rehabilitation of the Wayne State University School of Medicine, and physician in chief of Physical Medicine and Rehabilitation for the Detroit Medical Center. His appointment to the three positions simultaneously marks the first time PM&R services for the sprawling medical center complex have been centralized and coordinated through one physician-in-chief post. Doctor Gans comes to the Institute from Tufts University School of Medicine where he was chairman of the Department of Rehabilitation Institute at the England Medical Center in Boston.

Richard A. Morin, MD, is the new chief of psychiatric services at Detroit Riverview Hospital. Before joining Riverview, Doctor Morin was chairman of the Department of Psychiatry at Samaritan Hospital. He is currently an instructor at Wayne State University's Lafayette Clinic.

Sidney Friedlaender, MD, is the recipient of the Distinguished Alumnus Award given by the Wayne State University School of Medicine. Doctor Friedlaender is clinical professor of medicine at Wayne's School of Medicine, clinical professor of the University of Florida, J. Hillis Miller Health Center, and former director of the Occupational and Environmental Asthma and Allergic Disease Center of Sinai Hospital in Detroit. He has received many honors and awards for his contributions as a teacher, researcher, clinician, author, and medical editor. Doctor Friedlaender has served as president of national and state specialty societies, and is the founding director of the American Board of Allergy and Immunology.

Fred Whitehouse, MD, is the newest recipient of the American Diabetes Association (ADA) Award for the Outstanding Clinician in the Field of Diabetes. Doctor Whitehouse is chief, Division of Endocrinology-Metabolism, Henry Ford Hospital. He has been an active member of the ADA since the 1960s. He has served as president and board member of the Michigan Affiliate, vice-president of the Professional Section, and as president-elect and president of the national ADA.

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and several other small foundations.

GDAHC will administer the one-year Ford Motor Company Fund grant in support of a provider education project to be implemented by the Detroit Medical Society.

Outreach seminars will be offered to educate minority health care professionals, including physicians, nurses, social workers, dentists and other health care workers about HIV infection, AIDS, and AIDS-related illnesses to improve the clinical management of those populations at greatest risk.

According to Cecil Jonas, MD, a practicing physician and chairman of the Task Force on AIDS of the Detroit Medical Society: "A tremendous need and interest exists among minority health care providers to learn more about AIDS. Because minority health care professionals are often the first medical personnel to be contacted by those at particular risk in our community, it is essential that they be well educated about the clinical, moral, ethical, and legal aspects of AIDS."

Henry Ford Med Center breaks ground for new location

The Henry Ford Medical Center — Sterling Heights — celebrated the beginning of construction on its new location with a tree-planting event June 22.

The new 36,000-square-foot facility, located on the southwest corner of 15 Mile and Ryan Road, is scheduled to open in the spring of 1990. It will nearly double the space of the current site, located less than two miles away at 3058 Metropolitan Parkway, east of Dequindre Road. The Center opened at its present location in May of 1980.

The new Henry Ford Medical Center will feature a full-service pharmacy and 57 examination rooms. The Emergency Room, offering 24-hour emergency care services, will be larger and located on the first floor, offering more comfort and easier access to area residents as well as employees of nearby office buildings and industrial plants.

The Center will continue to serve the Sterling Heights community with care in 10 specialty areas — Internal Medicine, Pediatrics, Obstetrics/Gynecology, Allergy, Endocrinology, Occupational Medicine, Ophthalmology, Optometry, Pulmonary and Rheumatology. These services are complemented by on-site X-ray and lab facilities, an Optical Shop, and health, lifestyle and nutritional counseling.

Harper Hospital needs patients for study

The Gertrude Levin Pain Clinic located in the Harper Hospital Professional Office Building is looking for individuals to participate in a research study. The use of Trilisate, (a medication commonly used to treat arthritis patients), is being studied to treat individuals suffering from chronic low back pain.

Those who have had chronic low back pain for at least six months, and do not have psychological or drug-related problems are encouraged to participate. For further information on the study, call Susan Sluis, Pharm. D., Monday through Wednesday, 9 a.m. to 5 p.m., at (313) 745-9333.

Ted Koppel to moderate CME-accredited videoconference

Broadcast journalist Ted Koppel will moderate a live, interactive, CME-accredited videoconference, September 28, entitled, "Common Ground: An Interspecialty Approach to the Glaucoma Patient."

The videoconference —

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which will focus on the importance of communication between ophthalmologists and primary care physicians when treating the elderly glaucoma patient — will appear on the Hospital Satellite Network (HSN) and will be downlinked to over 15 hospital locations around the country.

It will air from 2 p.m. to 3:30 p.m. Eastern Standard Time.

The videoconference will feature a panel of leading ophthalmologists and primary care physicians who will discuss common issues surrounding the medical management of elderly glaucoma patients.

Physicians may register to attend by calling 800-833-3480. For more information on the videoconference, contact Carol Fontanella at (201) 273-9626.

The videoconference is approved for 2 Category I Credit hours.

Institute for reconstructive surgery announces toll-free number

The Institute for Craniofacial and Reconstructive Surgery has activated a toll-free telephone number to help referring physicians and potential patients inquire about the Institute's resources for consultation and surgery.

The toll-free number is 1-800-466-5800, nationwide. The Institute is an international resource for comprehensive consultation, diagnosis, treatment and follow-up for clinical cases requiring craniofacial and reconstructive interventions.

The Institute was established earlier this year in affiliation with Providence Hospital, Southfield. Internationally renowned physician Ian T. Jackson, MD, FRCS, FACS, formerly head of the plastic surgery section for The Mayo Clinic, Rochester, Minnesota, joined the Institute as director and a principal consultant and surgeon.

AMA president addresses MAPI

James E. Davis, MD, AMA president, was chief guest at the 14th annual dinner dance meeting of the Michigan Association of Physicians from India (MAPI) held May 13 at the Michigan Inn, Southfield. More than 365 people attended the meeting.

Doctor Davis addressed the various issues concerning foreign medical graduates, such as the program and licensing regulations for FMG's (Flex Exam) and the AMA's position on these issues.

Doctor Davis assured the audience that the AMA will work with state licensing boards to try to change any discriminatory licensing regulations. He stressed the need for physicians to stay united to fight against the worsening climate of medical practice. He reminded the audience about the AMA's fight with the HCFA on the issue of peer review sanctions.

AIDS research underway at Harper Hospital

An AIDS research project is underway at Harper Hospital aimed at finding drugs that will prevent the progression of the disease. Patients currently in the study have mild symptoms and have not developed pneumonia or cancer.

In the study, lower doses of AZT and Acyclovir are being administered to certain patients. Researchers hope that lower doses of these drugs would produce fewer side effects associated with the normal doses of AZT, and retard the progression of the disease at the same time.

Harper is one of 14 centers nationwide currently involved in this study. ■

Michigan State Medical Society

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ENVIRONMENTAL HEALTH HAZARDS

THE STATISTICS ARE STAGGERING

By Douglas A. Mack, MD

- In Freeland, a train carrying chemicals derails and burns, the toxic fumes forcing 1,000 local residents from their homes for days.
- In Menominee, five workers die in a farm pit, smothered from lack of oxygen and poisoned by inhalation of methane gas.
- On Lake Erie beaches, traces of medical waste wash ashore, repeating summer 1988 pollution nightmares.

These are examples of the environmental health hazards to which the public is exposed, and upon which MSMS members increasingly are focusing their attention.

Because of the closer scrutiny by MSMS members collectively and individually, environmental health hazards are the subject of this month's *Michigan Medicine* cover story.

In this issue you will find articles on medical waste problems, on hazards of indoor air pollution, and on safeguarding our lands and waters from radioactive waste pollution. A sidebar details one Michigan physician's efforts to reforest our country, thereby restoring natural resources and improving air quality.

Newly-appointed Michigan Department of Public Health Director Raj Weiner has announced environmental issues as among her priorities.

At the highest level of state government, Governor James Blanchard has established a Council for Environmental Quality, made up of 13 individuals. They include former MSMS Board Member Kenneth J. Rowe, MD, Hancock, who also served this year as temporary chief medical executive with the state health department.

The Council will map out environmental problems and priorities for the state, beginning with its first meeting in September.

Doctor Rowe's successor as chief medical executive, Kenneth R. Wilcox, MD, also an MSMS member, sees his role as helping the MDPH apply its skills and resources to the state's health problems.

He will help pull together some of the varied interests and directions so we can best deal with the problems from the public's perspective. "I will draw on my background in health and medicine to make us as operational as I can in dealing with the problems," he says.

With such state-level organization, concern and contacts, MSMS members are positioned well to have an impact on environmental health issues.

MSMS takes advantage of its contacts with state public health agencies through its Public Health Liaison Committee. Our committee coordinates activities on a regular basis with the Public Health Department.

We are spurred on this year by several resolutions of the 1989 MSMS House of Delegates, calling for action in key environmental health areas. They include calls that:

1) The AMA seek a coordinated national policy for disposal of low-level radioactive waste;

2) MSMS seek to assure protection of Michigan's natural resources, particularly its extensive fresh water aquifer, and to assure proper consideration of the public health and safety in the low-level radioactive waste disposal site selection process;

3) MSMS recommend appointment of a physician with expertise in radiological health to the Low-level Radioactive Waste Authority Review Board;

4) MSMS establish informational programs for members on the effects of chemical and radioactive toxic substances;

5) MSMS members continue to cooperate with MDPH officials in finding adequate ways to dispose of medical wastes, encourage the Michigan legislature and MDPH to develop simple rules to regulate medical waste, and oppose regulations creating cumbersome medical waste tracking mechanisms; and

6) MSMS decrease its own use, and encourage members to decrease their use, of nonbiodegradable products.

MSMS policy strongly backs efforts to improve environmental health. "As physicians and citizens, we realize the urgent necessity of curbing environmental pollution whatever its origin," we say.

With that as our standard, our Public Health Liaison Committee members urge you to read on, to inform yourselves of the latest developments, and to seek ways in which you can become involved in protecting our fragile and crucial environment. ■

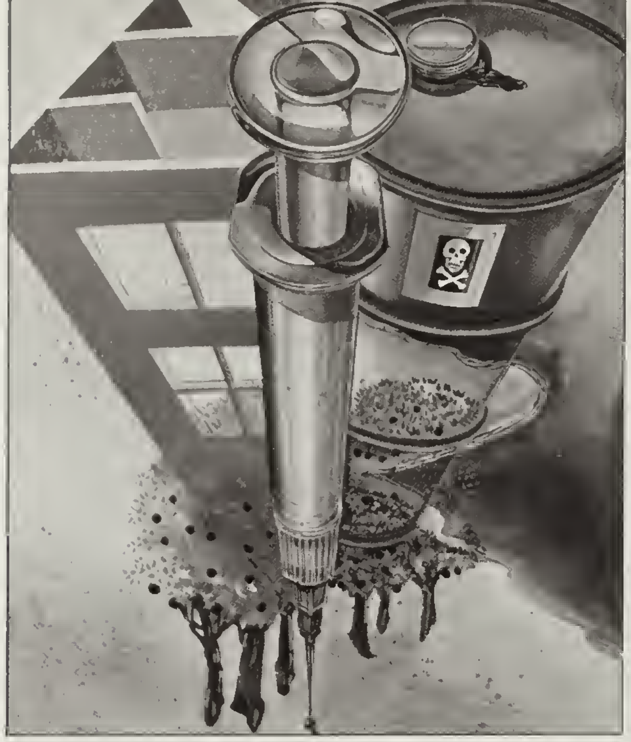
Doctor Mack is chairman of the MSMS Liaison Committee with the Michigan Department of Public Health.

Cover Story

INFECTIOUS MEDICAL WASTE

A MICHIGAN PERSPECTIVE

By Kenneth Rowe, MD



On September 12, 1988, the news media in Michigan reported a wash-up of medical waste on West Michigan beaches. Great concern was expressed about the possible risk to the public's health because of improper disposal of materials such as syringes, needles, blood vials and other medical waste. The investigation of the West Michigan incident revealed that approximately 70 insulin-type syringes had been found along with various other miscellaneous noninfectious items. The tremendous impact on the public was expressed by both the print and broadcast media.

The risk perceived by the public and the media — and the actual risk of disease transmission through improper disposal of medical waste — have been subjects of considerable debate in Michigan as well as across the country in the last nine months. The role of the medical community and of the Michigan Department of Public Health is to inform the public of the level of risk represented by this incident, as well as to assess the status of medical waste disposal and the generating facilities across the State.

Federal program

On a national level, the Federal Medical Waste Tracking Act was passed in 1988. The Act gave the Great Lakes states the option of participating in a program which would define medical waste, prescribe its containerization and transport, and require a manifest or logging system for handling each shipment of medical waste to its ultimate disposal site. On April 24, 1989, Governor Blanchard opted Michigan out of the federal program as did all the governors of the other Great Lakes states except New York, which did not have the option of participation.

Michigan program

The program of infectious medical waste control in Michigan has focused on achieving two goals. The first is to prevent disease transmission on-site, in transportation of potentially infected waste, and in disposal of that material. The second is to avoid environmental contamination and degradation of the soil by landfill disposal or of the air through incineration of the material.

In Michigan there are over 31,000 potential generators of infectious medical waste. Determination of the current disposal methods in Michigan was obtained through contact with individual facilities, individual professionals, and professional associations representing physicians, hospitals, dentists, veterinarians, as well as the waste transport industry.

When Governor Blanchard opted Michigan out of the federal program, he did so with the assurance that there were more cost effective ways of dealing with real and perceived infectious medical waste problems. The current Michigan program includes a set of emergency rules promulgated by the Michigan Department of Public Health and adopted in April of 1989. The rules are to assure that generators will dispose of a prescribed set of medical wastes in a manner which will prevent transmission to other individuals and will avoid environmental degradation. The rules consist basically of four parts:

1. The definition of infectious medical waste which would clearly identify those materials that have the potential of carrying infection from one individual to another or from a facility to a transporter or possibly to a community. In order for infectious medical waste to transmit disease, it must first have infectious organisms and be of such nature that it would enter into or cause a portal of entry for the organisms. This definition limited the scope of the medical waste primarily to sharps, blood and blood products, laboratory cultures, and pathological waste.

   Throughout the country and certainly the Great Lakes region there has been rather uniform agreement on the categories of medical waste which are potentially infectious and need to be handled in special ways.
2. The second part prescribes the manner in which waste is stored in containers at a generating facility or is disposed of on-site. Examples include the flushing of blood down sewers and the incineration of laboratory microbial waste.
3. The third part deals with means of containerization of infectious medical waste for transport and prescribes for the disposal of various categories of waste.
4. The fourth part requires each generating facility or professional to develop a medical waste management plan which would be retained on site. The management plan would include the type of waste generated, the means of containerization and disposal either on-site or transported, and a statement as to the ultimate disposal in a facility capable of dealing with such waste.

   The plan also provides some penalties for improper disposal of medical waste which is documented.

Pending legislation

Legislation is pending in Michigan which might alter infectious medical waste management. Drafts of bills currently being considered bear similarity to the rules in terms of definitions and methods of handling and containerization. There is the possibility that generators will be required to submit plans to the Michigan Department of Public Health and that generating facilities undergo on-site review of the management of medical waste. Resources to conduct such on-site surveillance would be given to the department in terms of fees which would accompany the management plan to be submitted. Another major effort of the Department of Public Health in dealing with the medical waste issue has been to communicate with professionals and facilities who are generators of waste, with the transport and disposal community. Other agencies within state and local government who deal with solid waste disposal, (i.e. law enforcement and others) have been a part of discussion groups. Public education of the actual risk of medical waste to human health is an ongoing effort. It is also a very important effort, not only of state agencies but also of individual professionals, professional associations and others.

The entire effort of education, public protection and development of legislation has been a cooperative effort between the Departments of Public Health, Natural Resources, and the Governor's Environmental Office, as well as the staffs of the public health committees of both the House and Senate. They made a very professional effort to determine the scope of the problem and to develop reasonable cost-effective measures which would safeguard the public's health. The problem is not over. The issue is not settled.

Disposal of medical waste as a subset of solid waste management will continue to merit close scrutiny of governmental agencies. The cooperation of the medical community is vital to the continued success of the effort. ■

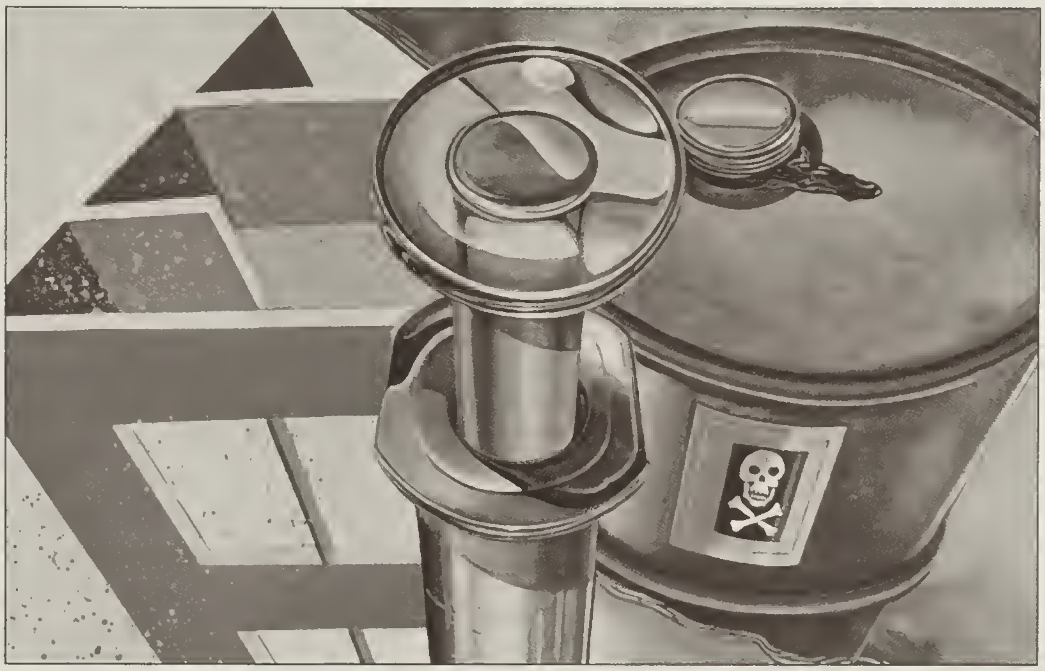
Doctor Rowe is director of the Western Upper Peninsula District Health Department and, until recently, served as chief medical executive of the Michigan Department of Public Health.

Cover Story

LOW LEVEL RADIOACTIVE WASTE DISPOSAL

A PUBLIC HEALTH CONCERN

By Mary Sinclair, MS



The medical profession has a keen interest in a solution for low-level radioactive waste disposal on a stable and continuing basis. Thus, development of present policy based on the 1980 Low Level Radioactive Waste Disposal Act and the subsequent 1985 amendments has stirred the concerns of many physicians. They know the Act and amendments have implications for the public health and environmental safety.

It is not uncommon for federal and state programs to be adopted as the result of political brokering and have them work reasonably well, but in this case the materials involved, so-called "low-level" radioactive wastes, according to the present definition by the Nuclear Regulatory Commission, have singular environmental and public health implications. These implications should have been addressed as part of the policy-making process, but were not. Therein lies the crux of the growing public controversy over this policy, and the reasons for physicians' concerns.

The Michigan State Medical Society identified a number of these issues in a resolution passed by the House of Delegates at their May 5-7, 1989, meeting in Dearborn. Noting that "the disposal of low-level radioactive waste significantly impacts public health and environmental safety," the resolution asked "the Michigan Delegation to the American Medical Association to request the AMA to call for evaluation of national policy regarding low-level radioactive waste disposal and to seek development of a coordinated national policy for the disposal of low-level radioactive waste."

Lack of policy, poor decision-making to blame

Behind this considerable request to the AMA lies the federal government's lamentable history of lack of policy and poor policy decision-making in the area of nuclear waste disposal which has preempted all licensing and decision-making on the use of the nuclear fission technology from its beginning.

Initial attempts at ocean dumping of both military and commercially generated waste were discontinued when broken and leaking canisters were found washed ashore. The Atomic Energy Commission (AEC) then allowed private managers to develop six landfill dumping grounds which were licensed by the government and located in various regions of the country but without any comprehensive federal plan. Three of those sites — at West Valley, NY, Sheffield, Ill., and Maxey Flats, Ky. — were shut down within a few years after they began to operate because they were found to be leaking radioactivity offsite and into nearby streams even though the sites were licensed as permanently safe by the AEC, now the Nuclear Regulatory Commission (NRC). At these three sites, water has infiltrated the disposal trenches and subsidence of earthen trench covers and erosion has occurred. Radioactivity has migrated offsite and expensive remedial actions are continuing. Within 10 years of trench closure, these sites now require continuous active monitoring and maintenance.

Since these closures, only three sites in the country have been accepting these wastes. They are located in Beatty, Nev., Hanford, Wash., and Barnwell, SC,

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using shallow land-burial disposal methods.

While the Michigan Legislature has ruled out shallow landfill burial as a disposal method and the Michigan Radioactive Waste Authority is considering various types of engineered structures, the fact is that there is no structure known that will last for the length of time that some of these wastes are hazardous — into the thousands of years. In evaluating the hazard of the contaminated reactor component rad wastes, which are the largest items of "low-level" waste, an NRC report states that the radiation dose rates from the long-lived radionuclides Nickel-59 (half-life, 80,000 yrs.) and Niobium-94 (half-life, 20,000 yrs.) are in those components which will "remain well above unrestricted release levels for a period of time far exceeding the known lifetime of any man-made structure." (NUREG/CR-0130, Feb.'78, p.v).

Other sources of so-called "low-level" wastes from reactors are the ion exchange resins which clean up the leakage of defective fuel rods and activated metals from corroding reactor internals into the reactor coolant and the fuel pool. All these intensely radioactive materials are the reasons why remote controlled equipment and special shielding are needed in handling "low-level" waste at nuclear plants. Yet the NRC calls all of these materials "low-level" and has licensed them for disposal together in shallow landfill burial grounds.

Medical radioactive waste in Michigan is minimal

Recent surveys show that in Michigan over 98 percent of the so-called "low-level" radioactive wastes come from nuclear power plants. Less than one percent come from medical wastes. (Survey, published January 27, 1987, Michigan Radioactive Waste Authority.)

To explain the significant difference between nuclear power wastes and medical radioactive wastes, Daniel S. Marks, MD, former president of the Michigan College of Nuclear Medicine and Ralph P. Lieto, a medical physicist, wrote a letter to *The Detroit News* to refute an editorial saying all nuclear waste was "potentially dangerous." They stated, "Nuclear power waste has very high levels of activity which may last for thousands of years. In comparison, all of the materials we use for medical purposes have extremely low levels of activity which last from only a few hours to several days. Lumping the two types of radioactive waste together is to give equality to an ocean and a glass of water because both are wet." They went on to say, "We do not need deep holes or abandoned mines in isolated areas for medical nuclear waste disposal. In a majority of cases, a small building, appropriately marked and shielded, would serve adequately."

Low Level Waste Policy Act passed

In the late 1970s, the Governors of the states where the current burial sites are located threatened to close their sites to all wastes if Congress did not act. In the final days of the hectic 1980 Congressional session, on Dec. 22, 1980, Congress passed the Low Level Waste Policy Act. In effect, Congress yielded to the pressures of these Governors and adopted a political solution for what is, in reality, a very serious environmental problem. This act makes each state responsible for all so-called "low level" radioactive wastes generated within its borders. The Act suggests that a regional approach whereby states would join together to form compacts would be the best solution to the problem.

A review of the legislative history indicates that Congress had no clear idea of the nature of the wastes for which they were passing disposal legislation. The major Congressional committee which was expected to give guidance on this issue was the Energy and Natural Resources Committee of the Senate. When Senator McClure of Idaho, the chairman, was asked what the nature of this waste was, he replied that this was "non-defense, non-nuclear power waste" and that it was mainly waste from research and medical facilities. (Congressional Record, Dec. 13, 1980, p. 33965.) As a consequence of this misinformation and lack of understanding of the real nature of these radioactive wastes, no environmental impact review or special siting criteria were required. Yet the National Academy of Science and National Research Council had warned much earlier that these wastes should not be placed in a humid climate or above any water table.(NAS Report of the Committee on Geologic Aspects of Radioactive Waste Disposal, May, 1966, p. 501.)

Michigan physicians take action on waste issue

A number of physicians around the country have studied these issues and their public health implications. In Michigan, they added these concerns about Michigan's water resources to the resolution passed by the House of Delegates in May, stating, "That MSMS seek to assure protection of Michigan's natural resources, particularly its extensive fresh water aquifer and to insure public health and safety in the low-level radioactive waste disposal site selection process." They further recommended appointment of a physician with expertise in radiological health to the Low-Level Radioactive Waste Authority Review Board.

In 1985, Congress passed additional amendments to this Act setting certain milestones for compliance by the states and imposing financial penalties for noncompliance. These amendments required that all states have in place a method of disposing of low-level radioactive waste by 1993 when the dumps now accepting them will close. They also required that each region select a host state for the dump by Jan. 1, 1988. Also, host states were required to establish guidelines for selecting a site by that date. In addition, these amendments require the states to take possession and assume liability for these wastes by 1996 if no facility has been established, even though the states have been barred by federal preemption from all licensing and siting decisions up to this point.

Michigan part of Midwest Compact

Michigan lawmakers agreed in 1982 to participate in a compact with the Midwest states of Indiana, Ohio, Iowa, Minnesota, Missouri, and Wisconsin. In June, 1987, Michigan was chosen the host state for the Midwest Compact based on the Commissioners' assessment that Michigan produced the most waste and was best accessible for transportation from all the participating states. They dismissed the requirement in the Compact legislation which Michigan's legislature had agreed to in 1982 that would "ensure the ecological...management of low-level radioactive wastes" despite the fact that Michigan is at the center of the Great Lakes, the source of 90 percent of the fresh surface water of the U.S.

The manner in which it was decided that Michigan is the logical candidate for host state for the Midwest also has come under considerable scrutiny and criticism. Almost 60 percent of the waste attributed to Michigan is generated at the Donald C. Cook twin reactors at Bridgman. But more than 91 percent of the electricity from those plants goes out of state to Indiana and Kentucky. Furthermore, in the past 18 months, Indiana Electric Power Co., which owns these plants, replaced the steam generators of Unit 2 which were highly corroded and contaminated with radioactivity. The company disposed of one-and-one-half million pounds of concrete and steel housing contaminated by

Ce-137, Ce-134 and Co-60 on the shores of Lake Michigan with no cover. The over two million pounds of the contaminated steam generators are stored in a concrete building less than a mile from the shore. This was approved by the NRC with no public hearing and no state review. In other words, Michigan not only derives very little benefit from the power generated by these plants, but must bear the consequences of the spent fuel storage, reactor operation, wastes produced by these plants, and accept the burden of the waste facility for the Midwest as a result.

A host of disturbing issues face the public

Within the past two years, a host of disturbing issues that only can be resolved by Congress has come into public view.

1) At present, there is no upfront money to pay for the facility. It is now known that any facility built in a humid climate such as Michigan will cost three to five times more than one built in an arid climate.

2) The fact that there is no liability coverage available from either public or private sources for either the short or long term storage of these wastes has loomed as a grave financial problem for the host states. Since February, Governor Blanchard has been negotiating with the other governors in the Compact to solve this problem. As yet, no solution has been announced.

3) It is now known that the volume of commercial wastes that is projected for the foreseeable future would require only two sites, or at the most four states, nationwide. Instead, more than 16 disposal sites are now being planned throughout the country as the states attempt to follow the regional or "compact" approach to disposal that was set out in the 1980 Low Level Waste Policy Act. This is a needlessly high cost for the nation and will discourage waste reduction as all the facilities seek more wastes to make their sites financially viable. A principal nuclear waste management firm, Chem Nuclear Systems, Inc., has warned utilities to rethink current national policy because the unnecessary proliferation of sites will cause the cost of disposal to "skyrocket ...perhaps by a factor of 10 or more" if the number of sites goes to eight nationwide. (Letter, April 28, 1987.) The number of sites now being planned is at least twice that figure. The cost of disposal now projected by the Michigan Radioactive Waste Authority will increase from less than $100 a cubic foot to $300 a cubic foot or more. Limiting the number of sites nationwide, and relief from the economic burden of the present proliferation of sites, is a problem that only the Federal government can resolve. The Michigan State Medical Society resolution asks for such a comprehensive, coordinated plan to address these issues.

4) The Radioactive Waste Control Committee has reported that only two percent of the radioactivity and seven percent of the volume nationwide are produced in the Midwest Compact area. If only two (and at most four) sites are needed nationwide, the question remains, should any of them be located in the Great Lakes region or in humid climate areas of the country?

5) The NRC plans to license every disposal facility for 100 years (the Institutional Control Period), but they will allow materials that are hazardous for thousands of years to go into them. Congress should require the Nuclear Regulatory Commission to redefine low level waste to include only those wastes which will decay to safe levels in 100 years. This has been advocated by such national organizations as the League of Women Voters and the Sierra Club, the international Great Lakes United, and in our state, the Michigan United Conservation Clubs.

Compact unsatisfactory

For practical, legal and social reasons, the present Compact approach is not going to be satisfactory for solving the low-level radioactive waste disposal problem in our nation.

There is a more responsible way to face this problem.

Michigan should withdraw from the Midwest Compact and arrange to have all the wastes held at reactor sites where over 98 percent of the radioactivity is generated and space is available. The utilities already are licensed to do this by the NRC for five years at a time. The wastes should be held there until such time as Congress addresses the many issues that can be resolved only at the federal level. All radioactive waste generators as well as the general public then will have a stake in getting Congress to address these issues and to "seek a coordinated national policy for the disposal of low-level radioactive waste" as the MSMS resolution has proposed.

The Radioactive Waste Authority can negotiate for disposal at reactor sites of the far less hazardous waste from research and medical sources which produce less than two percent of the radioactivity, based on costs similar to those they are already paying.

The poorly devised Low-Level Radioactive Waste Policy Act of 1980 and its subsequent 1985 amendments can have the effect of spreading dangerously toxic, long-lived radioactive wastes throughout the country with permanent and irreversible impacts on vital water and land resources that inevitably will profoundly affect human health and the economic well-being of our society. The need for the continuing operation of the research and medical facilities that serve the public today requires that an innovative approach be instituted which will allow for an orderly transition for their radwaste disposal until such time as Congress can establish an ecologically and economically sound plan for the disposal of these wastes nationwide.

The generators of medical and research wastes can be effective not only in securing proper interim storage of their wastes but also in influencing decision makers toward a sound, long-term solution to this problem. ■

The author is an employee of the University of Michigan, Environmental Communications.

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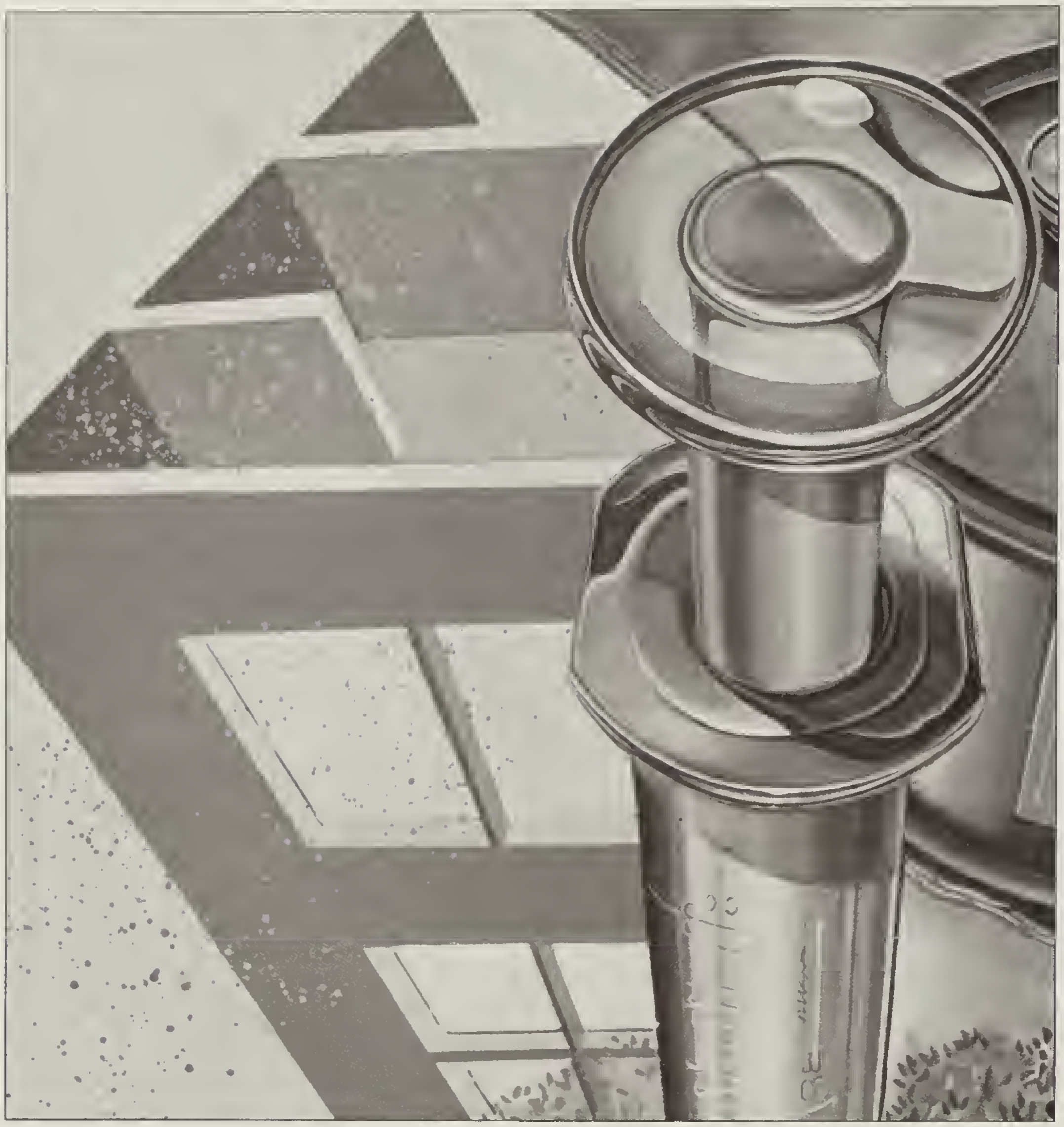


Cover Story

INDOOR AIR QUALITY

THERE ARE MANY CONCERNS, SAYS MDPH

Since the energy crisis of the 1970s, new buildings have been designed and many older buildings retrofitted for optimum energy conservation. Buildings are better insulated and better sealed to minimize the natural infiltration of air and are designed to reduce the amount of outdoor air brought in through the ventilation systems.

In the past, most people believed that significant exposures to air contaminants occurred only in hazardous industrial environments. However, energy conservation measures, as well as other factors, have contributed to numerous indoor air quality (IAQ) problems for the occupants of office-type buildings. A survey conducted by Honeywell revealed that 39 percent of office workers believe IAQ is a serious problem. But is it?

The Michigan Department of Public Health (MDPH), Division of Occupational Health, recently reviewed 40 cases of IAQ related complaints. The five most frequent offending agents included (1) inadequate ventilation, (2) contaminated building materials/inside contamination, (3) outside contamination, (4) tobacco smoke, and (5) viable organisms.

Inadequate ventilation the most frequent concern

By far, the experience by MDPH and other studies is that inadequate ventilation generates the majority of IAQ concerns. This may be in the form of insufficient amounts of fresh, outdoor air introduced to the building through the ventilation system. Even with an adequate volume of fresh air to the entire building, problems also can result due to non-uniform distribution to individual office spaces. Although ineffective ventilation systems do not typically cause air contaminant exposures that exceed regulated permissible exposure limits (PELs), they often lead to complaints of stuffiness, stale air or "lack of oxygen." Ineffective ventilation also will allow the buildup of inside air contaminants such as carbon dioxide and make the control of temperature and humidity quite difficult.

Air contaminant exposures the second major concern

The second most prevalent IAQ concern was caused by air contaminant exposures generated by equipment, such as copiers, or released by the building's construction material or furniture. An Environmental Protection Agency (EPA) study, released last November, looked at the airborne concentrations of many volatile organic compounds (VOCs) in 10 office buildings. Very small amounts of more than 50 VOCs were identified and suspected to have been released by office fixtures and/or tobacco smoke. While the health-related significance of such minute exposures is unclear, one contaminant — formaldehyde — has been found in concentrations typically much less than the PEL but great enough to cause eye and throat irritation to a certain percentage of the population. Formaldehyde may be released by certain carpets, cements, furniture items, and building materials.

Outdoor air contaminants the third major concern

A third and often significant source of IAQ problems is the introduction of an air contaminant from the outdoors. This can occur when a fresh air intake is located near a loading dock allowing vehicle exhaust to enter. In such situations, the most significant exposure may be to carbon monoxide from gasoline engines or irritating aldehydes and oxides of nitrogen from diesel engines. The introduction of outdoor contaminants also has occurred during roofing projects and from adjacent manufacturing plants.

Tobacco smoke a small, but significant concern

Tobacco smoke accounts for a small but significant percentage of IAQ problems. It increases the indoor respirable suspended particulates, is one of the most powerful irritants for those with a variety of respiratory diseases and may be especially troublesome for individuals with allergies.

Viable organisms a rare, but significant source

A fifth source of IAQ problems which is quite rare, but may be very significant, is viable organisms. In 1968, an epidemic of influenza-like illness occurred among employees and visitors of the county health department building in Pontiac, Michigan. The illness ultimately was linked to legionella pneumophila. Although such organisms are virtually everywhere in our environment in minute amounts, certain conditions can contribute to excessive propagation. Possible niches include uncleaned humidifiers, clogged drains, damp building materials, dirty air handling filters, poorly drained cooling towers and any stagnant water.

Such damp conditions also may promote the growth of certain molds and fungi which can cause an allergic pneumonitis for a very small percentage of the population.

Other concerns

Radon is another air contaminant which may be found in an office building. Although EPA estimates that 5,000 to 20,000 lung cancer deaths per year will be caused by this naturally occurring gas, its significance through exposures at work are not know at this time.

Although not a definite health hazard for most people, temperature and humidity extremes often are of concern to building occupants. Excessive temperatures and/or humidities can readily result in uncomfortable working conditions. Low humidities (less than 20 percent) also may result in dry throats, nasal passages, and eyes.

Finally, there are other situations that may lead to symptoms which are suspected of, but not actually related to, IAQ. These include excessive VDT use, improper lighting, glare, absence of windows, high noise levels, poorly designed office furniture, and even factors related to job stress or job dissatisfaction.

In conclusion, some conditions/exposures do lead to clearly definable occupational illness. Although the majority of IAQ problems cannot be easily linked to a specific air contaminant, condition or health hazard, they often are associated with employee discomfort. Nevertheless, such IAQ concerns must be addressed because they do effect people's productivity, absenteeism, and overall well-being. ■

This article was prepared by the Michigan Department of Public Health, Bureau of Environmental and Occupational Health, Division of Occupational Health.

Cover Story

MICHIGAN DOCTOR ENCOURAGES CHILDREN TO PLANT TREES, HELP ENVIRONMENT

Editor's note: *The following is excerpted from an article written by Bob Campbell,* Detroit Free Press *environment writer, published in the March 14 issue of the newspaper.*

Alfred Swanson, MD, admits he had a few ulterior motives when he came up with the idea to have children plant 10,000 trees in Kent County the last week of April.

Get children hooked on planting trees around their houses to fight the greenhouse effect and soon they will be badgering parents to recycle household trash or change wasteful habits, said the East Grand Rapids hand surgeon.

"There's a healing effect to doing this because it relates back to all the other environmental issues."

Doctor Swanson, chairman of Alternative Methods for International Stability — a group whose board of directors reads like a Who's Who of Grand Rapids — had another thought about the benefits of planting 10,000 4- to-7-foot-tall trees.

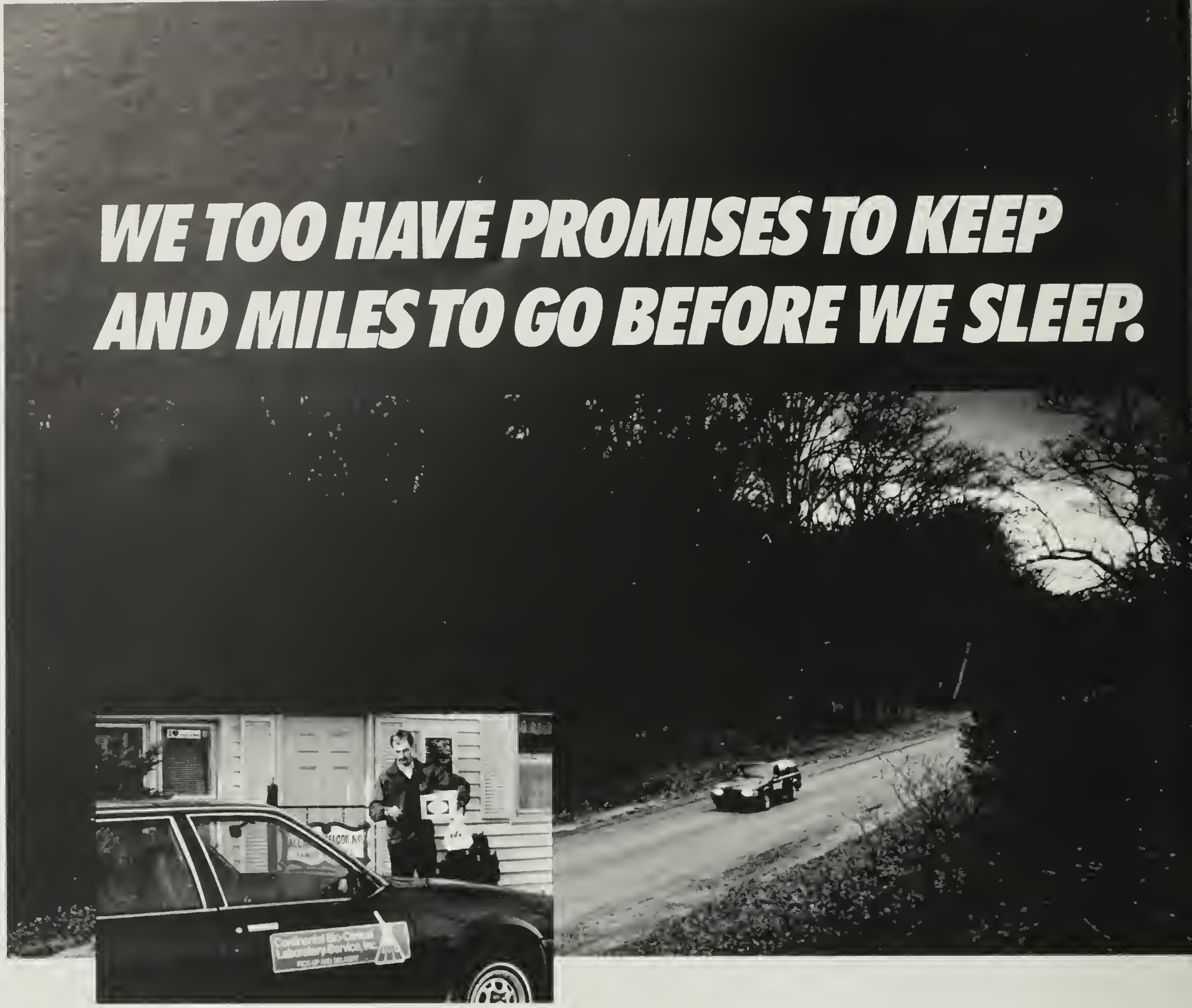
"What if challenging the rest of the county to join in the project boosted 10,000 trees to 100,000," he said. "And what if the 82 other Michigan counties also planted 100,000 trees each? Suddenly, 10,000 becomes 8.2 million. No sense keeping a good idea to Michigan, either."

If the 49 other states could match Michigan, there could be — read these leaves — 4.5 billion trees, all sucking up carbon dioxide.

Carbon dioxide is the gas that many experts fear will double in quantity in the atmosphere by the middle of the next century, trapping more and more of the sun's energy and causing the Earth to warm, the oceans to rise and general environmental havoc to ensue.

The Kent County trees — all bare root, 4- to 7-foot-tall hardwoods — were planted from April 22 to April 29, Arbor Day. High school students supervised fourth- and fifth-graders who planted the trees. The participants were known as the Western Michigan Tree Corps. About $80,000 was raised for the project, including $10,000 from Doctor Swanson and his wife and medical partner, Genevieve de Groot Swanson, MD.

Doctor Swanson, whose concerns about the planet grew out of his personal observations of the destruction of rain forests in South America and southeast Asia, carries his message to those countries, too, when he lectures on surgical techniques. He is a former president of the American Society for Surgery of the Hand. ■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CBC

MSMS Represents Members' Views In Amicus Court Cases

By Richard D. Weber and Joanne Geha Swanson

MSMS has expressed its views to Michigan's appellate courts on a number of legal issues which are of importance to Michigan's medical community. The following brief synopsis of the cases in which MSMS has participated over the past five years is provided by MSMS legal counsel to keep you informed of MSMS' amicus curiae "friend of the court" activity.

Palenkas v Beaumont Hospital

In *Palenkas,* the Trial Court reduced a medical malpractice verdict for the plaintiff from $1.2 million to $800,000, pursuant to a procedure known as "remittitur." On appeal, the Michigan Supreme Court was asked to determine whether the remittitur was proper. Up until that time, the "standard" for determining whether the amount of a verdict was excessive was the highly subjective "shock the conscience" test; i.e. does the verdict shock the judicial conscience? MSMS urged the Supreme Court to reject that standard in favor of a more objective inquiry, set forth in the state's court rules, designed to determine whether the verdict "exceeds the highest amount the evidence will support."

The Supreme Court's long-awaited decision was announced on June 7, 1989. As hoped, the majority opinion rejected the "shock the conscience" test as inappropriate because "it merely involves an expression of the trial judge's personal values and subjective beliefs and in no way relates to the actual conduct of the trial." The inquiry to be made is whether the amount awarded exceeds the highest amount the evidence will support. A comparison of jury awards in analogous cases may be considered as providing an "objective means of determining the range of appropriate awards in such cases." Other objective inquiries include whether the verdict was the result of improper methods, prejudice, passion, partiality, sympathy, corruption, or mistake of law or fact.

Kolosowski v Beaumont Hospital

Kolosowski is currently pending in the Court of Appeals on a more difficult remittitur issue. A five million dollar obstetrical malpractice verdict in favor of a five-year-old boy whose mother deemed him "smart" and the evidence as to which suggested mild mental retardation, was reduced by the Trial Court to $106,696.01. In finding the verdict grossly excessive, the Trial Court considered the investment potential of the verdict and opined that it would provide "a most luxurious and extravagant living which is available to few in the world."

The Court of Appeals has not yet rendered a decision in *Kolosowski.* Whatever the outcome, it most likely will be appealed to the Michigan Supreme Court. At that point, MSMS again will seek to participate as amicus curiae.

Jordan v Sinai Hospital

The Michigan Supreme Court recently rejected a request to review a Court of Appeals decision which bars a defendant in a medical malpractice action from informally interviewing the plaintiff's physicians without permission from the plaintiff. As amicus curiae, MSMS had urged the Supreme Court to accept the appeal and reverse the Court of Appeals decision. Ex parte (out-side the presence of the opposing party) interviews had been effectively used as an informal and inexpensive means of discovery for years. Sinai Hospital recently requested that the Supreme Court reconsider its refusal to decide the issue. That request is pending.

Monusko v Burns Clinic

This case could have a far-reaching impact on the practice of medicine in Michigan. MSMS has joined the defendants in asking the Michigan Supreme Court to review and reverse a Court of Appeals decision which, for the first time, recognized the existence of "preconception tort" as a theory of recovery in this injured by allegedly negligent conduct which occurred prior to the child's conception. MSMS has argued that this decision ignores the usual prerequisites to a medical malpractice action by allowing a physician to be sued by a person with whom no doctor-patient relationship existed. It also will create a conflict between a doctor's duty to advise appropriate treatment for his patient and the risk that treatment may pose to the patient's yet-to-be conceived children. It will indefinitely extend the period of time during which a physician may be subject to suit (effectively obliterating the statute of limitations in such instances) and runs counter to the legislature's recognition of the need for tort reform rather than expansion.

The Supreme Court has not yet determined whether it will decide this issue.

In the Matter of Joelle Rosebush

This "right to die" case is pending in the Court of Appeals after the Supreme Court rejected the parties' attempt to place the issue directly before the high Court. It involves the Oakland County Prosecutor's appeal of a Circuit Court decision authorizing the parents of 11-year old Joelle Rosebush to withdraw life support systems from their child notwithstanding the fact that "brain death" under Michigan Determination of Death Act had not occurred. Physicians who testified during the lower court proceedings diagnosed Joelle's neurologic injury as a per-

Continued on page 24

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sistent vegetative state that offered no chance for recovery. She did not respond to stimulation in even a remotely cognitive manner. However, she was not considered "brain dead" pursuant to Michigan's statute because part of her brain stem was not irreparably injured.

The Court of Appeals has granted MSMS permission to file an amicus curiae brief in support of the trial court's decision. Upon preparation of the transcript of proceedings in the Trial Court, appropriate briefs will be filed.

Palazzo v Teasdall

The plaintiff physical therapist in *Palazzo* recovered a substantial verdict against the defendants for tortious interference with a business relationship pursuant to which he performed electromyography upon referral from various physicians. To determine the propriety of that verdict, the Court of Appeals has been called upon to determine whether Palazzo's performance of electromyography was proper. MSMS has filed an amicus curiae brief in support of the proposition that electromyography is an inherently diagnostic procedure which constitutes the practice of medicine and is outside the scope of physical therapy license. Although this question has been bantered about by the affected professional associations for a number of years, the decision in this case will be the first pronouncement by a Michigan appellate court on this issue.

Morris v Metriyakool

The Michigan Supreme Court upheld the Medical Malpractice Arbitration Act against constitutional attack in *Morris.* It had been argued that the inclusion of a physician on the three-member arbitration panel violated constitutional guarantees of due process. It also had been argued that the agreement was an "adhesion contract" and was otherwise unconscionable. The Court rejected these attacks. The amicus brief filed by MSMS supported the statute in all respects.

McKinstry v Valley Obstetrics & Gynecology Clinic

The enforceability of arbitration agreements which conform to the requirements of the Medical Malpractice Arbitration Act was before the Michigan Supreme Court in *McKinstry.* As amicus curiae, MSMS asserted that the parties seeking to avoid an arbitration agreement which otherwise conformed to the statute, bore the burden of proving the agreement's invalidity. On another issue, MSMS argued that an unborn child is bound by an arbitration agreement signed on its behalf by a parent. The Michigan Supreme Court favorably decided both issues.

Duvall v Goldin

The Michigan Supreme Court declined a request to determine the propriety of a Court of Appeals decision which held that a physician's duty of care extends to unidentifiable third persons who are harmed by the physician's treatment of a patient. Plaintiffs were injured in an automobile accident which occurred when their vehicle was struck by the defendant-doctor's patient. It was alleged that the defendant-doctor knew or should have known that his patient had previous epileptic seizures as to which he had failed to prescribe or continue anti-epileptic medication and/or instruct him not to operate a motor vehicle. The Supreme Court's refusal to decide the issue left the Court of Appeals decision standing.

Attorney General v Bruce

The Michigan Supreme Court affirmed the confidentiality of the records of a hospital peer review committee and prohibited their discovery by the Board of Medicine and the Department of Licensing and Regulation. As amicus curiae, MSMS asserted that the Michigan Public Health Code, which required licensed hospitals to conduct continuing internal peer reviews of its professional staff, provided for the confidentiality of information collected by a peer review committee and protected it from disclosure through the judicial discovery process. The rationale for this protection was to maintain an uninhibited and candid atmosphere for peer review committee discussions to improve the care and treatment of hospital patients.

Monty v Warren Hospital

This case involved the disclosure of peer review committee records in a malpractice case. The Michigan Supreme Court reversed a Trial Court order which required committee records to be produced in open court. The Court would not accept the proposition that records are confidential under the peer review statutes merely because the hospital says they are. The Supreme Court held that the records must be produced for a private analysis by the presiding judge to determine whether they really fall within the peer review function. If the Court determines that they are truly peer review records, their confidentiality will be maintained, as argued by MSMS. ■

MSMS Legal Counsel Answers Members' Questions

Editor's note: Michigan Medicine *is pleased to introduce a new column in which MSMS legal counsel answers your questions about medical practice law. The following answers are provided by Richard D. Weber, of Kerr, Russell & Weber, Detroit.*

Question: When a newly-retired physician seeks to collect his accounts receivable through his office manager, what, if any, regulatory requirements must he comply with?

The Law: In Michigan, when a person seeks to collect for old debts, his/her actions normally are governed by the "Collection Practices Act," which can be found under Section 339.901 et seq. of the Michigan Compiled Laws Annotated. Generally, the Act requires individuals who are engaged in the collection of debts to first become licensed as a collection agency and then abide by certain good faith solicitation requirements.

However, before we can discuss the specific requirements of the Act, it must be determined whether or not the Act actually applies to the situation described above. First, Section 901(a) defines a "claim" or "debt" as "an obligation or alleged obligation for the payment of money or thing of value arising out of an express or implied agreement or contract for a purchase made *primarily for personal, family, or household purposes.*" Mich. Comp. Laws Ann., 339.901(a)(West 1981)(emphasis added). Since the nature of a patient's debt to a physician is generally considered to be for "personal" or "family" purposes, it appears that the Act was designed to address the collection of such debts.

Secondly, Section 901(b) broadly defines "collection agency" as "any person directly or indirectly engaged in soliciting a claim for collection..." However, this broad language is limited by the listing of certain exceptions which the Act will not apply to. Specifically, Section 901(b) says that a collection agency:

> ...does not include a person whose collection activities are confined and are directly related to the operation of a business other than that of a collection agency such as, but not limited to, the following:
>
> (i) *a regular employee* when collecting amounts for one employer if all collection efforts are carried on in the name of the employer...

Michigan Comp. Laws Ann., 339.901(b) (i) (West 1981) (emphasis added).

The main issue with this exception is whether the office manager mentioned above falls within the definition of a "regular employee" as used in Section 901(b) (i). The Collection Practices Act is relatively new, adopted in 1980 and amended in 1981, and thus far, it has not been significantly interpreted by the Michigan courts. However, it appears that a former office manager who receives as pay for collection of an accounts receivable, a percentage plus an hourly rate, could easily fall within the meaning of a "regular employee" per Section 901(b) (i).

Conclusion: Therefore, as long as the office manager who collects for the physician qualifies as a regular employee per Section 901(b) (i), he will be exempted from the requirements of the Collection Practices Act. Hence, he will not have to establish himself as a licensed collection agency nor abide by any of the other requirements of the Collection Practices Act.

Question: May a physician advertise by using an assumed name or as a professional corporation?

The Law: MCLA 750.298 governs this issue. MCLA 750.298 provides:

> Any person who shall practice medicine or advertise to practice medicine under a false or assumed name, or under a name other than his own, shall be guilty of a misdemeanor, punishable by imprisonment in the county jail not more than one year or by a fine of not more than $500.

The Attorney General Opinion listed in the annotated section of MCLA 750.298 reaffirms the principle that an individual may not advertise under an assumed name while engaging in the practice of medicine.

In *Lewis v Michigan State Board of Dentistry,* 277 Mich 334, 269 NW 194 (1936), the court held that the practice of dentistry under an assumed name such as "Peerless Dentists" or "Dr. Doe's Modern Dentists" was forbidden by statute. Furthermore, the court held that a dentist must use his exact name, as embodied in his license, in order to be in compliance with the statute regulating the practice of dentistry. The court was motivated to require that a dentist disclose his full name (as it appeared on his license to practice) in order to protect potential patients from fraud. Accordingly, by requiring disclosure of the physician's name, patients will be aware of a practitioner's true identity.

Conclusion: In light of the Attorney General Opinion and the court's decision in *Lewis,* it is my conclusion that when a physician is advertising, he may not do so under an assumed name. In addition, were a physician to advertise as a professional corporation (i.e. D. O.C.), that practitioner should make full disclosure of his name in the advertisement as it is listed on his license to practice. For example, if my client were Dr. John Smith and he wanted to advertise his D. O.C. office, I would advise him to advertise as "D. O.C." and to conspicuously display "Dr. John Smith" under the D. O.C. title. ■

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NCUA EQUAL HOUSING LENDER 5/89

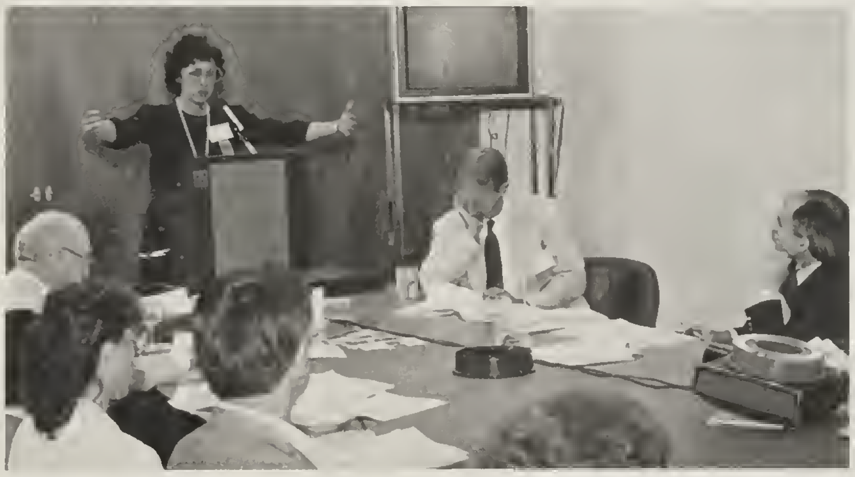
MSMS
AIDS EDUCATION
CONFERENCE HIGHLIGHTS

The Michigan State Medical Society furthered the outreach of the AIDS Provider Education Project by offering a special AIDS education session June 14 for county medical society presidents and executive directors. Almost 35 attended the session to hear some of Michigan's foremost experts present the latest on the new Michigan AIDS laws, patient communication issues, diagnosis and treatment of the HIV infected patient, and universal precautions in the office setting. As part of his opening comments, Fred W. Bryant, MD, chairman of the MSMS AIDS Provider Education Task Force, said: We have the ability to take a leadership role, to put into place counseling techniques and to understand the diagnosis and treatment of this disease."

Evelyn Fisher, MD, Henry Ford Hospital, urged that steps be taken to ensure that the patient has an established support network prior to administering the HIV test.

Fred W. Bryant, MD, chairman, MSMS AIDS Provider Education Task Force, (left) stated in his opening comments that it is important for physicians to come to grips with the fact that AIDS is not curable but it is, at this point in the epidemic's progress, an inevitable part of medical practice — just as heart disease and cancer are present realities. Patsy Villegas (right), counselor, Ingham County Health Department, was on hand to answer questions regarding counseling practices when offering the HIV test.

Participants took advantage of the many AIDS/HIV support materials available at the MSMS AIDS Education Office and through the Professional AIDS Information Network (800-522-0399). MSMS also continues to sponsor experts through the MSMS AIDS Speaker's Bureau. Any health care agency in need of a speaker (at no charge) is invited to contact the MSMS AIDS Education Office.


During her presentation on the new Michigan AIDS laws, Marie Inniss, JD, assistant dean, Wayne State University, emphasized the marriage license requirement does not mandate testing for sexually transmitted diseases or HIV infection. Rather, applicants are to be counseled about transmission and prevention and are to be offered tests for both.

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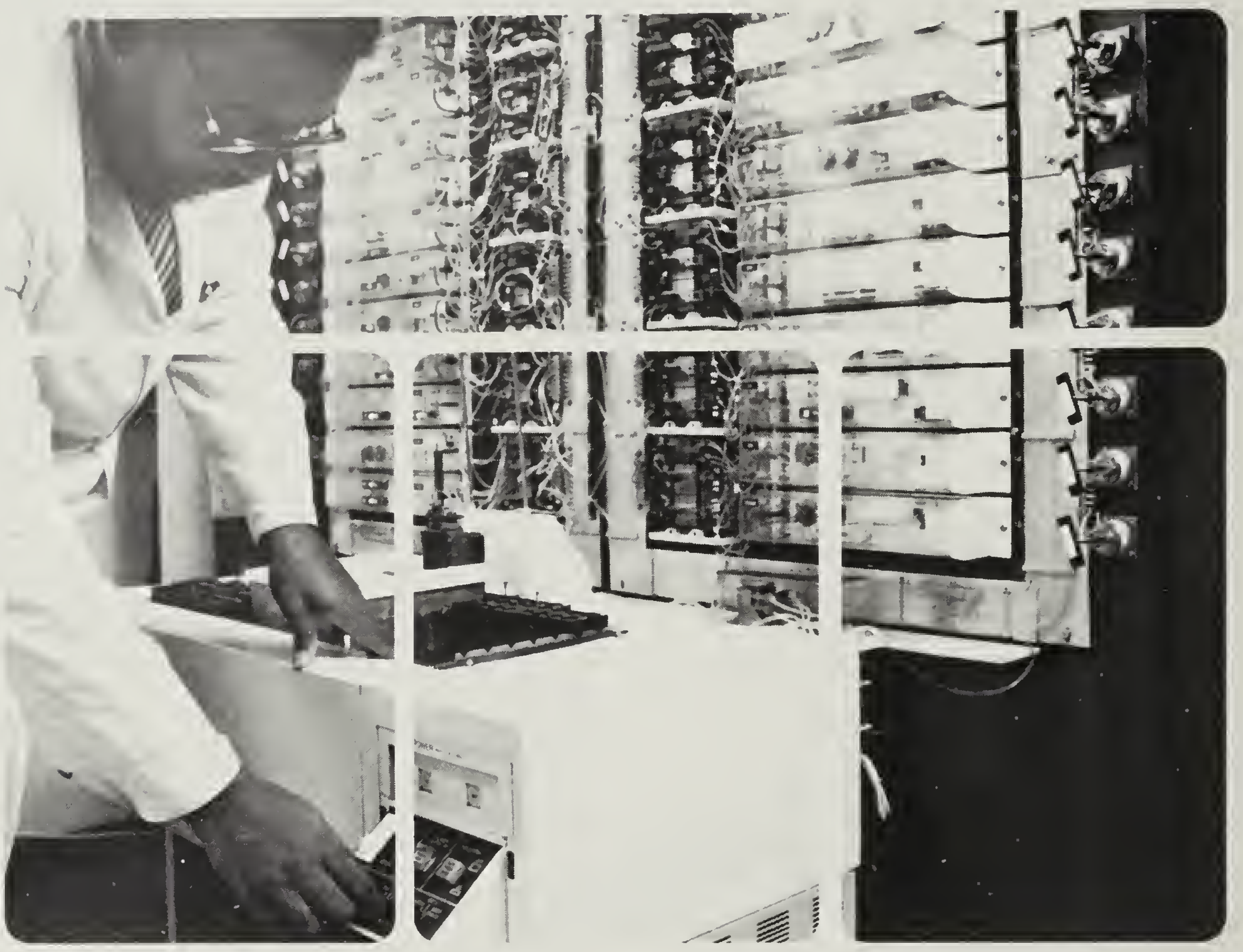

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Michigan's Triplicate Prescription Program Now In Effect

By Larry D. Wagenknecht

The success of Michigan's triplicate prescription program requires the cooperation of all physicians and pharmacists.

Effective August 1, 1989, Michigan joins several other states with the implementation of a triplicate prescription program for Schedule II controlled substances. Public Act 60 of 1988 was part of a legislative initiative intended to curb drug diversion and substance abuse in the state. The law also created a Controlled Substances Advisory Commission that will be responsible for monitoring the program. The Controlled Substances Advisory Commission will report and make recommendations to the Governor, Legislature and state agencies concerning the prescription drug problem. The success of the Michigan's triplicate prescription program requires the cooperation of all physicians and pharmacists.

Public Act 60 mandates that all Schedule II controlled substances must be written on official state-issued triplicate prescription forms that are physician specific, preprinted, and serially numbered. Prescribers are required to order personalized triplicate prescription forms from the state which are supplied free of charge by the state. Prescribers must use their own triplicate prescription forms when prescribing Schedule II drugs for patients. The use of hospital prescription forms or other physician's triplicate prescription forms is not acceptable.

Public Act 60 also mandates that triplicate forms may not be pre- or post-dated. All forms must be signed and dated on the day they are issued. The new law also requires that only one Schedule II controlled substance may be prescribed per form and that the prescription forms may only be used for Schedule II drugs. As with all schedules of controlled substances, the quantity of the drug must be in both written and numeric terms.

As the prescriber, you are required to enter the patient's name, address and age on each prescription. The prescriber must keep the third copy of the prescription form and must retain the copy for five years. The prescriber gives the original and second copies to the patient to take to the pharmacy. The pharmacist is required to provide dispensing information and forward the original copy to the Department of Licensing and Regulation by the 15th of the month following the month in which the prescription is filled. The pharmacist retains the second copy for a period of at least five years.

A number of exceptions

The triplicate prescription law does identify several exceptions to the use of triplicate prescription forms. The official prescription form is NOT required when the Schedule II drug is administered to a patient in the prescriber's private practice office, when ordered and administered to a patient in a hospital licensed by the departments of public or mental health, or when the Schedule II controlled substance is administered to a patient on the premises of a licensed health facility or agency. In each exception the order for a controlled substance must be entered in the patient's record. The types of licensed health facilities and agencies other than hospitals specified in the Michigan Public Health Code include freestanding surgical outpatient facilities, HMOs, county medical care facilities, nursing homes, homes for the aged, hospices, clinical laboratories, ambulances, advanced mobile emergency care services, and limited advanced mobile emergency care services.

The greatest public policy change in the law creating the triplicate prescription program is that which establishes a distinct time period that Schedule II drugs must be dispensed. The new law mandates that the triplicate prescription must be filled with *72 hours* from the date the prescription was issued. This change in the law will require that physicians remind their patients of the new three-day requirement. Since the law does not allow for pre-dating of prescription forms it may be necessary for physicians who prescribe Schedule II drugs for chronic illnesses to modify their prescribing habits. Many prescription insurance plans limit the days' supply of medication that can be dispensed to the patient at one time; thus increasing the quantities prescribed may not solve the problem for a patient with a chronic need for the Schedule II drug. Without proper planning the 72-hour requirement may create a burden on the patient.

Emergency situations

Public Act 60 retains the ability for dispensing Schedule II drugs in an emergency situation. In an emergency, a prescription for an "emergency" quantity only of a Schedule II drug may be communicated verbally to the pharmacist as long as the prescribing practitioner promptly completes a triplicate prescription form and forwards the original and second copy to the pharmacist within 72 hours after the verbal prescription is issued. Federal law requires that a pharmacist report to the Drug Enforcement Agency if copies of the official triplicate prescription form are not received in 72 hours. This is because of frequent attempts of individuals falsely identifying themselves to obtain controlled substances. The pharmacist in an emergency situation may wish to call the physician back in order to verify identity. With the increased difficulty in forging the triplicate prescription forms, the "emergency verbal prescription" may become a more frequently-used source of fraudulently-obtained controlled substances for diversion.

To assist physicians in determining which drugs are included in the triplicate program, Table 1 is a listing for frequently prescribed Schedule II controlled substances organized alphabetically by generic name and provides the most common trade name and dosage forms. The list is not intended to be inclusive of all Schedule II drugs.

Table 2 is a listing of common drugs and classes of drugs that are sometimes confused as being Schedule II, but in fact are Schedule III and Schedule IV drugs.

MICHIGAN STATE MEDICAL SOCIETY ANNUAL REPORT 1988-89

*Saluting 1988-89 MSMS leaders,
and reviewing the year's progress.*

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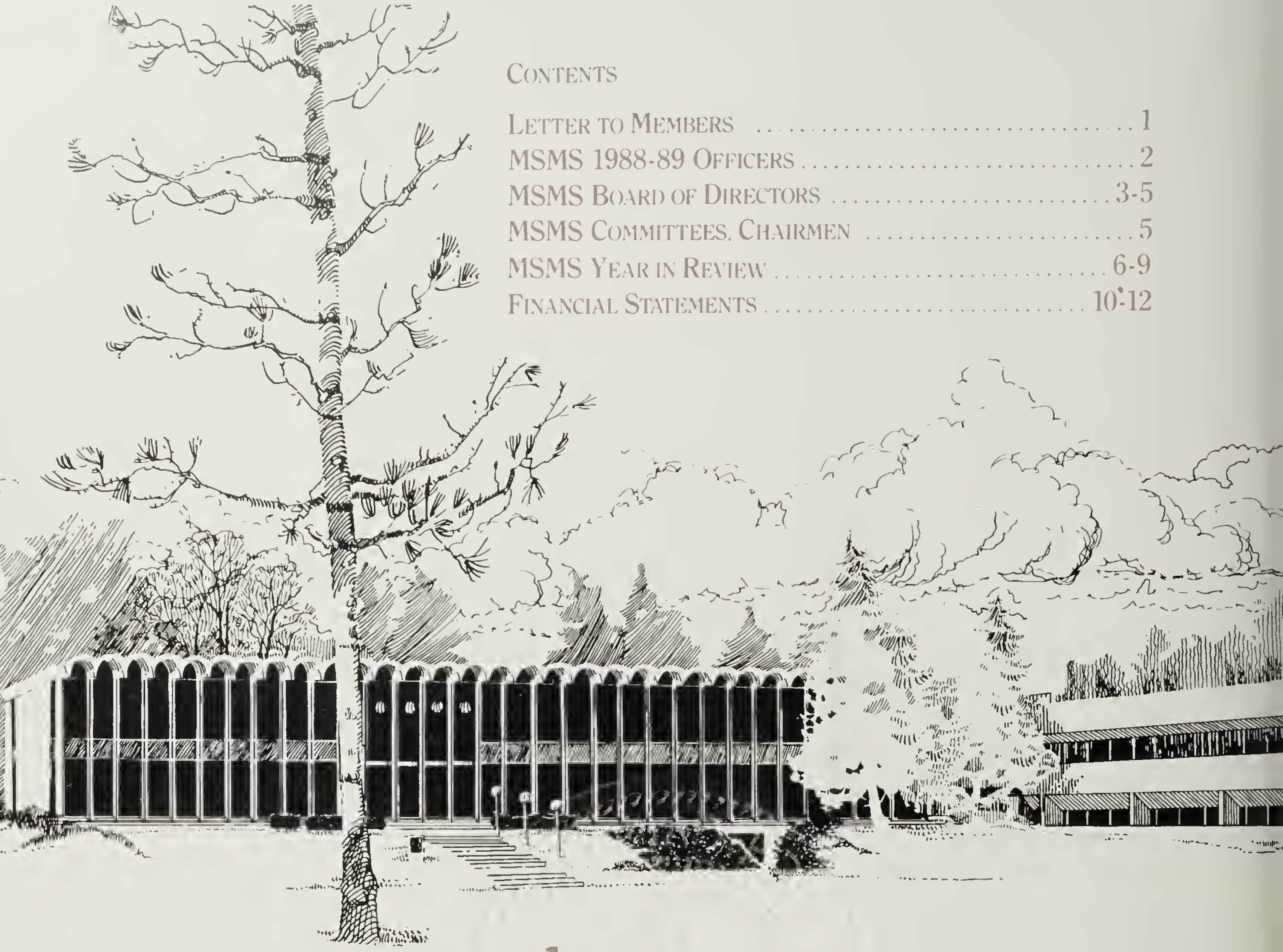


Architect Minoru Yamasaki created a building of unusual design and unique construction to house the Michigan State Medical Society. Combining elegance with utility, the structure's timeless style belies its 1959 construction.

The building stands on an elevation surrounded by three-and-one-half acres of beautifully landscaped grounds. Its 31 gracefully curved, 55-foot-long vaults of pre-cast concrete rest on 64 vertical columns. The columns and side walls are made of quartz aggregate surface concrete. Nearly 80 percent of the exterior of the building is gray non-glare glass. The main structure is 155 feet long, 46 feet wide, and encloses 20,000 square feet of floor space.

A circular drive off Saginaw Street offers access to the raised terrace extending the full length of the building. The off-center front entrance is recessed and opens into a two-story high reception area.

Behind the building, terraced steps rise from the large parking lot to the main entrance. Sheltered by large trees, the rear of the structure is equally imposing as the front.

LETTER TO MEMBERS

It is an honor and a pleasure to present to you the 1988-89 MSMS Annual Report.

This report is just one example of our solid commitment to informing the membership about the inner workings of MSMS – an organization which can (and is) increasingly being described as progressive, energetic, exciting, action-oriented, and perhaps most importantly, democratic.

WILLIAM E. MADIGAN
Executive Director

MSMS accomplished many of its goals and objectives in 1988 and is on its way to accomplishing many more in 1989 – thanks to the tremendous involvement of the membership.

I am happy to report that there are many more physicians involved with the Society than ever before. More than 550 physicians are involved in MSMS committees, 700 members are represented in the MSMS House of Delegates, not to mention a very active 34-member Board of Directors.

Strong member involvement and commitment led to the development and consideration of 154 resolutions at the 1989 MSMS House of Delegates meeting – the highest number of resolutions in recent memory. The AMA and other state medical societies have told us that the average number of resolutions considered by other states ranges between 15 and 50; MSMS always has had nearly 75 resolutions. This year, we *doubled* our resolutions. Now that's involvement! But there's more to the story.

In 1988, MSMS dealt with nearly three times as many legislative issues as in the preceding year. This explosion of political activity was fueled, in part, by the interests of many groups outside the medical arena. Thanks to member input and support, MSMS was able to effectively address these issues.

Despite the many accomplishments of the past year, many challenges lie ahead, challenges that will require continued member participation to overcome.

Now, more than ever, government is becoming involved in the practice of medicine. I urge you to keep in contact with your state senators and representatives on a regular basis so they know you and have confidence in you. Your voice in Michigan politics is a powerful one; I encourage you to use it and use it often. Keep in mind that politicians do listen to MSMS lobbyists and your leaders, but they are more likely to act when they get pressure from the grass roots.

Involvement is so important. If you're already participating in MSMS activities, I thank you and encourage you to stay involved. If you're not involved, take a moment to study the pages of this annual report and see for yourself what MSMS can accomplish with the help of many committed and dedicated members, and then make your own commitment to serve through MSMS participation.

Saluting 1988-89 Officers

Fred W. Bryant, MD
President

Doctor Bryant, *Royal Oak ophthalmologist, is chairman, MSMS AIDS Provider Education Task Force. A graduate of the University of Michigan Medical School, he is a member, American Academy of Ophthalmology.*

Robert E. Paxton, MD
President-Elect

Doctor Paxton, *Fremont family physician, has held numerous MSMS posts, including delegate, chairman of the Ways & Means and Finance committees, and board member of MDPAC. A graduate of the University of Illinois Medical School, Doctor Paxton is a member of the board, Michigan Academy of Family Physicians.*

Carl A. Gagliardi, MD
Immediate Past President

Doctor Gagliardi, *Dearborn pediatrician and medical educator, is past chairman, MSMS Board of Directors. He has served as chairman, MSMS Professional Liability Task Force. Doctor Gagliardi is a graduate of the Yale University School of Medicine.*

Thomas R. Berglund, MD
Secretary

Doctor Berglund, *Portage family physician, is past MSMS president and Board chairman. He is past chairman of AMPAC and currently serves as president of the Michigan Physicians Mutual Liability Company. Doctor Berglund is a graduate of the University of Michigan Medical School.*

Billy Ben Baumann, MD
Treasurer

Doctor Baumann, *Pontiac clinical pathologist, is vice chairman of the AMA delegation; president of the board of directors, Physician Service Group, Inc.; member of the board of directors, Michigan Physicians Mutual Liability Co.; and past president of the Oakland County Medical Society and the Michigan Society of Pathologists. He is a graduate of the Washington University School of Medicine, St. Louis.*

Robert D. Burton, MD
Speaker

Doctor Burton, *Grand Rapids otorhinolaryngologist, is a graduate of the University of Michigan Medical School. He is chairman of the Michigan Delegation to the AMA, past president of the Kent County Medical Society and current co-chair of the Kent County Medical Society's Legislative Committee. Doctor Burton is also recipient of the 1988 MSMS Flag Award for distinguished leadership.*

Robert D. Allaben, MD
Vice Speaker

Doctor Allaben, *Detroit surgeon, is a member of the Michigan Delegation to the AMA. He is a member of the Board of Trustees, Transplantation Society of Michigan, and is a member of the Board of Directors, Organ Procurement Society of Michigan. Doctor Allaben received his medical degree from the Wayne State University School of Medicine.*

Donald K. Crandall, MD
AMA Representative

Doctor Crandall, *Muskegon general surgeon, is past president of MSMS. A graduate of the University of Michigan Medical School, he is a member of the Michigan Delegation to the AMA and is chairman of the AMA Council on Medical Service.*

Board of Directors

Frank B. Walker, MD
Chairman

Doctor Walker, *Grosse Pointe Farms pathologist, has been a member of the MSMS Board of Directors since 1980. He is chairman, AMA Council on Long Range Planning and is a member of the AMA Board of Trustees. A graduate of the Wayne State University School of Medicine, Doctor Walker is treasurer of the American Board of Pathology.*

Jack L. Barry, MD,
Vice Chairman

Doctor Barry, *Saginaw family practitioner, is vice chairman of the MSMS Board of Directors. He also is MSMS Board representative to the MDPAC Board. A graduate of the Wayne State University School of Medicine, he is currently medical director of St. Mary's Bridgeport Medical Center. He also serves as a medical director for Health Plus of Michigan.*

Susan H. Adelman, MD, *Detroit pediatric surgeon, is chairman of the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan; chairman of the Wayne County Medical Society Board of Trustees; and an editor of* The Detroit Medical News. *She is a graduate of the Wayne State University School of Medicine.*

Robert W. Black, MD, *Detroit internist, is chairman, Board of Directors, Michigan Health Care Education Research Foundation and is a member of the Board of Directors, Blue Cross Blue Shield of Michigan. A past president of the Detroit Academy of Medicine, he received his medical degree from McGill University, Montreal.*

R. Jack Chase, MD, *Grand Rapids internist, is former chairman, MSMS Committee on Cost Containment and board member of MDPAC. An alternate delegate to the AMA, he is a member of the boards of trustees, Butterworth Foundation and Butterworth Hospital. He is a graduate of the University of Michigan School of Medicine.*

Henry M. Domzalski, MD, *Detroit urologist, is chairman of the MSMS Committee on Publications and the MSMS Advisory Committee on Communications and Professional Relations. A member of the Wayne County Medical Society Board of Trustees, Doctor Domzalski received his medical degree from the University of Michigan School of Medicine.*

Lionel E. Dorfman, MD, *Battle Creek urologist, has held a variety of posts with MSMS and other professional organizations, including member of the board of directors, MDPAC, and delegate to the MSMS House. He earned his medical degree from the University of Toronto.*

Peter A. Duhamel, MD, *Rochester general surgeon, is chairman, MDPAC, and member, Governing Council, MSMS Hospital Medical Staff Section. A past president of the Oakland County Medical Society, Doctor Duhamel is a graduate of St. Louis University.*

James L. Fenton, MD, *Bay City radiologist, is past president of the Michigan Board of Medicine and the Bay County Medical Society. He is a graduate of the Wayne State University School of Medicine.*

David H. Gilbert, MD, *Calumet surgeon, is a graduate of the University of Michigan School of Medicine.*

John W. Hall, MD, *Petoskey urologist, is past chairman, MSMS Committee on Publications, and heads the Board's Com-*

mittee on Scientific and Educational Affairs. He is a graduate of the University of Michigan School of Medicine.

Carl F. Hammerstrom, MD, *Marquette pulmonary and critical care specialist, is former chairman, MSMS Committee on CME Programming. He is a trustee of the Michigan Society of Internal Medicine and of the American Lung Association of Michigan. He earned his medical degree from Johns Hopkins University.*

Kenneth B. Herrington, MD, *Bad Axe internist, has served as president, Huron County Medical Society, and district director, Michigan Society of Internal Medicine. He is a graduate of the University of Michigan School of Medicine.*

Richard P. Horsch, MD, *Farmington anesthesiologist, is president, Michigan Society of Anesthesiologists; past president, Wayne County Medical Society; delegate to the MSMS House; and is associate editor of* Detroit Medical News. *He is a graduate of the Wayne State University School of Medicine.*

W. Peter McCabe, MD, *Grosse Pointe Woods plastic surgeon, has held a variety of posts with MSMS and other professional organizations including vice chairman of the Physicians Insurance Company of Michigan. A past president of the Wayne County Medical Society, he earned his medical degree from Cornell University.*

Frederick V. Minkow, MD, *Bloomfield Hills orthopedic surgeon, is a graduate of the University of Michigan School of Medicine. He is former chairman of the MSMS Committee on State Legislation and Regulations, past president of the Oakland County Medical Society and former chairman of the Oakland County Medical Society's legislative committee.*

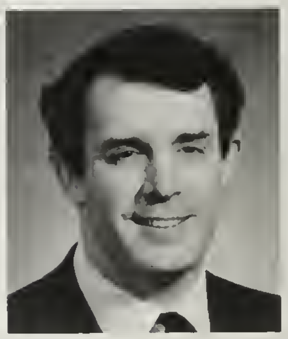
Earl G. Moehn, MD, *a Mount Clemens general surgeon, is past president of the Macomb County Medical Society and is a Fellow of the American College of Surgeons. He has served as chairman of the MSMS Committee on Constitution and Bylaws and is a graduate of the Wayne State University School of Medicine.*

Fred E. Patterson, MD, *Jackson radiologist, is director of radiology at Foote Memorial Hospital. He is former chairman of MSMS Public Affairs/Leadership Conference and is a past president of the Washtenaw County Medical Society. He received his medical degree from the University of Iowa College of Medicine.*

Thomas C. Payne, MD, *Lansing diagnostic radiologist, is former MSMS assistant secretary. He is past chairman, MDPAC, and is former chairman, MSMS Public Relations Committee. He is a graduate of the University of Cincinnati School of Medicine.*

Richard L. Rapport, MD, *Flint thoracic surgeon, heads the Board's Health Care Delivery Committee. He is past president of the Genessee County Medical Society and is a member of the Board of Directors, Physicians Review Organization of Michigan. He is a graduate of the Wayne State University School of Medicine.*

Marguerite Shearer, MD, *Ann Arbor family physician, is medical director of the Huron Valley Physicians Association. A graduate of the University of Michigan School of Medicine, she is a director, Michigan Academy of Family Physicians.*



Willard S. Stawski, MD, *Grand Rapids surgeon, received his degree from the University of Michigan Medical School. He is a former delegate to the MSMS House and is former president and secretary-/treasurer of the Kent County Medical Society.*

Thomas E. Stone, MD, *Muskegon urologist, is a former delegate to the MSMS House as well as past president of the Muskegon County Medical Society. He also is past president of MDPAC. He received his medical degree from the University of Michigan School of Medicine.*

MSMS COMMITTEES AND CHAIRMEN

Arthur A. Ulmer, MD, *Grosse Pointe Shores obstetrician/gynecologist, is past president of the Wayne County Medical Society, and is a member of the Wayne County Executive Committee and numerous OB/GYN professional organizations. He received his medical degree from Wayne State University School of Medicine.*

B. David Wilson, MD, *Kalamazoo allergist, is a member of the Board of Directors, MDPAC. He is an alternate delegate to the AMA and is past president of the Kalamazoo Academy of Medicine and Michigan Allergy Association. He received his medical degree from Wayne State University School of Medicine.*

Special guests invited to every MSMS Board of Directors meeting are: **Busharat Ahmad, MD,** *representing the MSMS Section for Graduates of Foreign Medical Schools;* **Brad Eisenbrey, MD,** *representing the MSMS Resident Physician Section;* **James Ilko, MD,** *representing the MSMS Medical Student Section;* **Gary D. Maynard,** *MD, representing the MSMS Hospital Medical Staff Section;* **Joyce Mann,** *representing the MSMS Auxiliary; and* **Richard A. Stone, MD,** *representing the MSMS Young Physicians Section.*

Committee on Aging
James G. O'Brien, MD

Task Force on AIDS Education
Fred W. Bryant, MD

Liaison Committee with Michigan Medical Arbitration System
Rhoda M. Powsner, MD

Committee on Awards
Billy Ben Baumann, MD

Committee on Bioethics
Howard A. Brody, MD

Liaison Committee with Blue Cross Blue Shield of Michigan
Susan H. Adelman, MD

Board of Managers
Billy Ben Baumann, MD

Advisory Committee on Communications and Professional Relations
Henry M. Domzalski, MD

Committee on Constitution and Bylaws
James E. McGillicuddy, MD

Committee on CME Accreditation
Donald J. Aiken, MD

Committee on CME Programming
David R. Rovner, MD

Liaison Committee with Corporate Medical Directors
Richard H. Gascoigne, MD

Steering Committee to Develop A Graduates of Foreign Medical Schools Section
Busharat Ahmad, MD

Advisory Committee on Health Care Policy
Fred E. Patterson, MD

Steering Committee on Program to Assist Impaired Physicians
James L. Fenton, MD

Judicial Commission
George W. Morley, MD

Committee on Maternal and Perinatal Health
Robert P. Lorenz, MD

Advisory Committee to Section on Medical Economics
Gilbert B. Bluhm, MD

Task Force on Rural Health Care
Fred W. Bryant, MD

Medicaid Liaison Committee
Cecil R. Jonas, MD

Committee on Medical Licensure and Discipline
Rhoda M. Powsner, MD

Committee to Review Member Insurance Programs
B. David Wilson, MD

Committee on Membership Recruitment and Retention
Dorothy Kahkonen, MD

Liaison Committee with Michigan Department of Public Health
Douglas A. Mack, MD

Michigan Doctors Political Action Committee Board of Directors
Peter A. Duhamel, MD

Liaison Committee with Michigan Peer Review Organization (MPRO)
Robert C. Packer, MD

Advisory Committee on Office Automation
Jack L. Barry, MD

Planning Committee for Michigan Conference on Maternal and Perinatal Health
Steven M. Donn, MD
John R. Addy, MD

Planning Committee for MSMS Annual Scientific Meeting
Joan C. Stryker, MD

Committee on MSMS Policy Manual
Robert D. Burton, MD

Board of Directors, Physician Service Group, Inc.
Billy Ben Baumann, MD

Task Force on Professional Liability
Robert E. Paxton, MD

Committee on Publications
Henry M. Domzalski, MD

Committee on Sports Medicine
Perry W. Greene, Jr., MD

Interprofessional Committee with State Bar of Michigan

Committee on State Legislation and Regulations
Mitchell A. Rinek, MD

Committee on Ways and Means
Fred W. Whitehouse, MD

Committee on Concerns of Women Physicians
Dawn E. Springer, MD

Advisory Task Force on Implementation of Young Physicians Section
Richard A. Stone, MD

Committee on Federal Legislation
Thomas E. Stone, MD

Task Force to Plan Public Affairs Leadership Conference
Mitchell A. Rinek, MD

Hagadorn, Inc.
Leland E. Holly, MD

Committee of Specialty Society Presidents
Robert E. Paxton, MD

MSMS/MI Hospital Association Liaison Committee

Governing Council, Hospital Medical Staff Section
Gary D. Maynard, MD

Governing Council, Resident Physicians Section
Gabriel R. Pereira, MD

MSMS Year in Review

A report by
Frank B. Walker, MD
Robert E. Paxton, MD
and
Fred W. Bryant, MD

Frank B. Walker, MD

Robert E. Paxton, MD

Fred W. Bryant, MD

Professional Liability, AIDS Education, Risk Management, Liaison with Government and Third Party Organizations, Physician CME, Member Services — All Are Key Areas in Which MSMS Members Are Active Today. And There Are Plenty More.

In late 1988, after careful review of the many issues facing Michigan physicians, MSMS leadership and staff identified 14 top issues for 1989. Shortly thereafter, the MSMS Board of Directors approved a plan of action for these issues as outlined by MSMS leadership and staff. To reinforce the importance of this plan, the items were enumerated in an attractive poster format for easy reference and retrieval.

This plan of action resulted in progress in several areas, particularly professional liability. A progress report on the Society's professional liability efforts appears later in this report.

In addition to professional liability — the number one issue for 1989 — key items of importance include:

- Discussions with the Legislature concerning *integrated licensure*, looking at the State Bar system as a model.
- Developing a *risk management* program to help physicians minimize exposure to lawsuits.
- Continuing the *AIDS Provider Education Program* through funding by Michigan Department of Public Health and working with the State Bar to develop policy statements aimed at legal protection for physicians who care for AIDS patients.
- Developing a quality institute in conjunction with the Michigan Hospital Association and continuing emphasis by MSMS on *quality health care* in the face of cost containment.
- Continuing to provide high quality *physician education* for continuing medical education credit.
- Addressing 20 *hospital medical staffs* to keep local physicians updated with various issues and activities.
- Continuing advocacy efforts on behalf of Michigan physicians with *third party payors*.
- Serving as a gatherer and disseminator of information concerning the Harvard *Resource-Based Relative Value Scale*.
- Seeking legislation to create a joint MSMS/Board of Medicine program for diverting physicians in need into the *Physicians Recovery Network* and to seek alternative funding for the network.
- Establishing liaison with the Michigan Office of Services to the Aging and the Michigan Chapter of AARP to discuss and promote issues in *elder care*.
- Increasing efforts to serve as a reliable source of information to the public and media through *media and public relations*.
- Increasing *non-dues income* through activities of Physician Service Group, Inc., Peer Review Organization of Michigan and Hagadorn, Inc.

As always, MSMS will continue to emphasize component society activities, member communications, recruitment and benefits. The goal of all MSMS activities is to ensure the availability of, and access to, quality medical care for the people of Michigan.

MSMS leadership and staff are committed to accomplishing the goals outlined above. Not to be overlooked, however, are the many goals MSMS — its leadership and staff — already accomplished in 1988. The following report reviews the many goals accomplished during the past year, plus some highlights of current MSMS programs. We encourage you to read on.

STATE LEGISLATION

MSMS aggressively dealt with many health care legislative issues proposed during the 1988-89 legislative year. Although much of the focus of the Legislature was on the 1988 statewide elections, MSMS continued to actively pursue its legislative agenda.

The primary legislative focal point for MSMS in 1988-89 again was on the professional liability issue. Several pieces of legislation were introduced at the behest of MSMS, in an effort to curtail the ever-rising insurance premiums paid by Michigan physicians. These bills, designed to improve the reforms passed by the Legislature in 1988, include removing several of the exceptions placed on the non-economic damage limitation, reducing the statute of limitations for minors, and allowing countersuits to be filed against the attorneys of individuals who have filed frivolous lawsuits.

There seems to be a growing consensus in the legislative arena that relief from the high cost of medical liability insurance can be accomplished only through the study and development of non-tort alternatives. Responding to this awareness, MSMS introduced legislation that would allow health insurers to offer health care policies with binding arbitration as an alternative mechanism to resolve medical disputes. MSMS has been successful in urging the Governor to again appoint a medical malpractice factfinder, Robben Fleming, to study further changes and/or alternatives to the medical liability insurance system.

MSMS efforts are ongoing in the study of a fault-based liability model, patient compensation funds, state medical liability trust fund and the Swedish no-fault system. In August, 1989, MSMS, MHA, Michigan Trial Lawyers Association, PICOM, MPMLC, and Michigan Hospital Association Mutual Insurance Company will host key lawmakers in a visit to Sweden for on-site study and education on the Swedish no-fault liability system.

A top priority issue of MSMS in 1988-89 has been to pass legislation to protect physician qualified retirement plan assets from garnishment in bankruptcy proceedings. In response to the defeat of this legislation in 1988, and in an effort to build a strong working relationship with physicians, the new Speaker of the House, Representative Lewis Dodak, committed to work with MSMS to pass the pension plan protection legislation. This legislation passed both legislative chambers in winter 1989 and was signed by the governor in April.

MSMS was successful in working with the Speaker of the House to appoint a special ad hoc committee to study the current physician licensure and discipline system in Michigan. MSMS expects the House committee to do an in-depth study and comparison of the effectiveness of both the state attorney discipline system and the physician licensing and discipline system in Michigan.

In their continuing efforts on behalf of MSMS, Fred Bryant, MD, and Rhoda Powsner, MD, have actively participated in the committee discussions pointing out several structural and functional problems within the current physician licensing and disciplinary system. MSMS expects continued study and discussion with the House committee through the fall of 1989.

MSMS continues to monitor attempts by non-physician groups to expand their scope of practice and/or gain licensure in Michigan. MSMS successfully defeated again a legislative proposal attempting to expand the scope of practice for chiropractic.

Dominating the legislative agenda in 1988 was the discussion and passage of a multifaceted package of bills related to crime and drug enforcement. MSMS actively supported and aided in the passage of a statewide triplicate prescription program. This program is designed to reduce the illegal dispensing and trafficking of Schedule II controlled substances in Michigan. It is effective August 1.

Upon the direction of the House of Delegates, MSMS worked to introduce legislation to regulate and promote safe use of All-Terrain Vehicles (ATVs) in Michigan. With the efforts and help of Elliott Grysen, MD, MSMS was successful in the development and utilization of a mass media campaign aimed at promoting and educating people on the safe use of ATVs. MSMS hopes for passage of the ATV regulation legislation in 1989.

AIDS was among the most controversial public health concerns MSMS addressed in legislative efforts this year. A five-bill package enacted in December reflects the joint efforts of several state agencies and organizations, including MSMS. The new laws, all of which took effect April 1, address AIDS testing and reporting, and public health measures to prevent spread of the AIDS virus.

In its work on AIDS legislation, MSMS was successful in enacting a provision relating to a physician's "duty to warn" sexual contacts of AIDS-infected patients. MSMS advocated a flexible duty-to-warn statute, which would allow a physician to notify partners of infected persons or allow a physician to seek the assistance of public health officials in partner notification activities. The law specifies that physicians disclosing information under this provision are immune to liability for breach of confidentiality.

Reforming the state's Certificate of Need system was a legislative priority in 1988. The MSMS Board of Directors adopted several principles for CON reform in 1987, all of which were incorporated in the reforms in late 1988. These principles include an increase in the capital expenditure threshold for CON regulation, physician involvement in the development of CON review criteria for covered equipment, the inclusion of quality considerations in CON reviews, and review and revision of all existing planning policies.

MSMS will continue to monitor the effect of CON reforms on Michigan physicians and their patients.

MSMS continues its efforts to increase awareness and participation of MSMS members in the state legislative process. MSMS physicians have demonstrated an increased ability to affect legislation as it relates to the medical community.

LEGAL ACTIVITIES

MSMS devoted substantial legal activity to legislative matters. Legal Counsel advised on multiple bills affecting physicians. Of particular significance was the legislation to protect qualified retirement plans from collection proceedings by judgment creditors, and the multi-package AIDS legislation which passed the Michigan Legislature.

Professional liability continued to generate considerable activity. Legal Counsel assisted in implementing the participation of physician members on mediation panels and coordinating the program with component societies. Ongoing analysis occurred with respect to the State Medical Liability Trust. *Feiger* v *Coleman*, the case contesting the constitutionality of the 1986 tort reform legislation, was dismissed by the trial court and the dismissal was affirmed by the Michigan Court of Appeals. The dismissal was based upon procedural grounds and Legal Counsel assisted in opposing the suit.

The chiropractic antitrust litigation continued during the past year. The sixth Circuit Court of Appeals reversed the summary judgment granted in favor of MSMS, AMA and others by the Federal District Court. The summary judgment was based upon the antitrust statute of limitations. The case has been remanded and trial is expected within the next year.

The Board authorized Legal Counsel to file four amicus curiae briefs. Briefs have been filed in *Palenkas* v *Beaumont Hospital*, regarding the appellate standard to be applied to remittitur, and *Palazzo* v *Teasdalle*, regarding the legal authority of physical therapists to perform electromyography. Counsel is preparing briefs *re: Rosebush*, regarding the right to determine medical treatment, and *Jordan* v *Sinai Hospital*, regarding the right of defense counsel in a malpractice case to confer with the treating physician.

Legal activities continue in the areas of assessing alternatives and modifications to the tort system relative to professional liability.

COMMUNICATIONS AND PROFESSIONAL RELATIONS

The MSMS media campaign to focus the attention of the public and Legislature on the continuing medical liability crisis resulted in favorable media stories, editorials and legislative commitments. Particularly effective were news releases on the residents' survey showing an exodus of young physicians from Michigan and a release on a Great Lakes state insurance rate comparison study.

During the year, MSMS President Fred W. Bryant, MD, talked to scores of newspaper, radio and television reporters on a variety of topics affecting medicine. During an October media tour, he visited 18 media outlets in the Upper Peninsula and northern lower Michigan in three days.

Calls from the media to MSMS asking for input on numerous stories increased dramatically throughout the year as MSMS has established itself as a credible source with the statewide media.

Two public service campaigns, the first in many years, have helped to show that MSMS physicians care about the welfare of our citizens. The first was a campaign to inform unsuspecting parents about the dangers of their children riding all-terrain vehicles (ATVs). Coupled with the release of public service announcements to all television and radio stations in the state was an intense media visitation program by Elliot Grysen, MD, of East Lansing, who originally proposed the project. Through his efforts and those of Senator John J.H. Schwartz, MD, the Legislature is poised to pass new laws restricting the use of ATVs by children.

The second campaign, to increase the public's awareness of the need for organ and tissue donation, was jointly introduced by the State Bar of Michigan and the Michigan Hospital Association. Again, MSMS released television and radio public service announcements. A brochure available to all attorneys, physicians and hospitals in the state and donated billboards have appeared statewide. The campaign has won awards from professional groups representing the public relations and advertising fields.

The January issue of *Michigan Medicine* introduced a completely new design for the magazine. The new format is professional and inviting to readers. Reactions from readers have been favorable. The magazine continues to provide physicians with monthly information about issues affecting health care delivery and other news of MSMS members and activities.

Medigram, the weekly newsletter, is increasingly used to disseminate information about MSMS and PSG seminars, conferences, goods and services. As an experiment, *Medigram* will soon begin to carry selected advertisements.

PROFESSIONAL LIABILITY

Health Policy Agenda/Michigan Patient Compensation Fund Demonstration Project.

The Project Steering Committee is pursuing a system to compensate infants with birth-related injuries as a model for developing a broader system of compensating patients injured in the course of medical treatment.

The Steering Committee has formed four work groups to facilitate its work:

Data — to gather data that describes medical liability in Michigan, especially birth-related injuries.

Legislation — to review the Virginia and Florida birth injury statutes and to recommend legislation for a Michigan birth injury statute.

Access to Obstetrical Services — to study access to obstetrical services in Michigan.

Licensing and Regulation — to study hospital and insurance company risk management programs in obstetrics.

On March 21, the Work Group on Legislation met with Martin Hatlie, Office of the General Counsel, the American Medical Association, and Kenneth Heland, administrative director of professional liability, the American College of Obstetricians and Gynecologists. The participants at the meeting first reviewed the Virginia and Florida statutes to compensate birth-related injuries then developed the essential features for similar legislation in Michigan.

Medical Liability Factfinder

MSMS is pleased that Governor Blanchard appointed Robben Fleming and Jay Rosen to resume the medical liability factfinding project of 1985-86. Doctor Fleming and Mr. Rosen will be meeting with MSMS and other interested parties to review the impact of the 1986 tort reform legislation and to explore additional measures to improve the medical liability climate.

"We're in the Same Boat" Brochure

MSMS developed this patient education brochure in conjunction with the Wayne County and Oakland County medical societies to show how the liability crisis has escalated and how the crisis affects the patient directly. The brochure included pre-addressed post cards to the Governor and leaders of the Legislature urging that they work to reduce the cost of medical liability insurance and to establish a task force to study alternatives for settling claims. Physicians across Michigan ordered about 30,000 of the brochures last summer and fall and mailed about 9,000 of the post cards.

Media Campaigns

During the year press releases and visits by MSMS leaders to newspaper editorial boards continued to keep the medical liability crisis in front of the public and the Legislature. Particularly successful were releases based on studies conducted by MSMS on the number of resident physicians who are planning to leave Michigan because of the high cost of liability insurance. In addition, an MSMS release compared the cost of liability insurance in Michigan with surrounding Great Lakes states.

BLUE CROSS/BLUE SHIELD OF MICHIGAN ACTIVITIES

Top management changes were made as a result of alleged financial improprieties, with the most notable change the resignation of John McCabe, BCBSM's chairman and chief executive. He was succeeded by Richard Whitmer, senior vice president and general counsel. Larry Sell, MD, senior vice president for health care affairs and the highest ranking physician within the company, now reports directly to the chief executive.

For several reasons, MSMS supported the renewal of BCBSM's contract with the federal government to serve as fiscal intermediary for Medicare Part A: (1) A transition to a new carrier likely would increase administrative costs, and create an extended period of confusion; (2) A new bureaucracy would result, to which MSMS would have less input than it does currently with BCBSM; and (3) BCBSM has corrected to a large extent most of the known deficiencies noted by HCFA.

The MSMS/BCBSM Liaison Committee, chaired by Susan E. Adelman, MD, met twice in 1988 to review individual physician complaints with BCBSM and to facilitate their resolution. In addition, MSMS staff provided information to and directly assisted many physicians in resolving reimbursement problems with BCBSM regular business and with Medicare, for which BCBSM serves as the Part B carrier.

MEMBERSHIP RECRUITMENT AND RETENTION

Membership continued to grow in 1988 to a total of 11,313 members. The 11,313 includes 8,608 regular members, 266 residents, 550 students, 899 life members, and 990 retired members. The Membership Department processed 687 new members, 116 members who died, 116 who moved out of state, and 291 who were dropped for non-payment of dues. Seventy-seven of those members dropped were reinstated after payment was received.

The AMA membership ranks also grew from 10,854 in 1987 to 11,065 in 1988. This increase allows Michigan an additional delegate to the AMA House of Delegates. Michigan now has 12 delegates and 12 alternates.

PHYSICIAN EDUCATION

MSMS plays a major role in the education of physicians and many allied health professionals through presentation of conferences and seminars, publications and an expanded program of jointly-sponsored CME activities with other groups.

Programs in 1988 covered nearly every medical specialty and scientific subject offering Category I Credit, as well as many topics on leadership, financial matters and practice management.

The MSMS Annual Scientific Meeting and the annual Michigan Conference on Maternal and Perinatal Health drew a total attendance of about 1,300 physicians and 600 nurses, students, technicians and others involved in the health care field. These annual conferences alone provided over 10,500 hours of Category I CME credit to physicians.

MSMS also jointly sponsored 18 conferences with specialty societies, county medical societies and medically-related organizations which awarded nearly 3,000 Category I credits to physicians.

PHYSICIANS RECOVERY NETWORK

The Physicians Recovery Network (PRN) continues to be an important program of the Michigan State Medical Society. Despite a substantial cut in its budget last spring, much progress has been made during the past year under the leadership of James L. Fenton, MD, chairman of the Steering Committee to Assist Impaired Physicians, and Gerald A. VanderVoord, MD, medical director of PRN.

The PRN office receives five to seven calls daily, and new cases are being opened each week. It now is following over 65 active cases and investigating 20 open leads. PRN keeps in continuous touch with over 110 recovered physicians it has assisted previously.

Assisting sick physicians remains PRN's top priority. However, if it is to continue this vital role it is essential that adequate financial resources be obtained.

AIDS PROVIDER EDUCATION PROGRAM

The MSMS AIDS Provider Education Program, operating this year under a $271,000 contract with the Michigan Department of Public Health, continued to play an important role in the Michigan response to AIDS.

The MSMS AIDS Speakers Bureau reached 17,000 health professionals in 1988 including physicians, nurses, social workers, pharmacists, first responders, dentists and dental hygienists. Nearly 100 experts throughout the state now serve as part of the Speakers Bureau, using resource materials — slides, videotapes, brochures and other written materials — developed through the MSMS Speakers Bureau.

MICHIGAN RURAL HEALTH FORUMS

In an effort to assist rural physicians, MSMS created a resource physician group. The responsibilities of these resource physicians are to generate a liaison with the physicians who attended the September 1988 invitational Rural Health Forums to become familiar with the challenges of a small rural medical practice, and to serve as resource physicians to the rural physicians who are participating on their community blue ribbon committees on health care.

The MSMS Task Force on Rural Health Care gathers information on the increasing challenges of change occurring in rural health care. It helps physicians make the necessary practice changes in order to continue to provide quality health care to rural Michigan residents.

LIAISON WITH OTHER ORGANIZATIONS

MSMS continues to coordinate ongoing liaison with a number of statewide organizations. Liaison activities emphasize those issues and areas upon which MSMS and other organizations can have a joint impact. During 1988, MSMS continued to work with organizations to achieve solutions for the professional liability problems in Michigan. MSMS meets regularly with the Michigan Hospital Association, the Michigan Dental Association, the Economic Alliance for Michigan, the State Bar of Michigan, Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Council of Deans, and the Michigan Board of Medicine. ■

BALANCE SHEET

Michigan State Medical Society

November 30, 1

ASSETS	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Tota
CURRENT ASSETS:						
Cash and cash equivalents (Note A)	$ 977,557	$ 19,943	$146,041	$ 23,080	$ 686	$1,16
Short-term investments (Notes A and B)		774,775	164,836	82,562		1,02
Accounts receivable (Notes A and F):						
Unconsolidated subsidiaries	34,028					34
Advertisers and other	88,033					8
Due from (to) other funds	178,610	(150,509)	(23,101)	(5,000)		
Current portion of notes receivable from unconsolidated subsidiaries	30,000					30
Accrued interest receivable	44,505	3,023				47
Prepaid expenses	47,612	429				48
TOTAL CURRENT ASSETS	$1,400,345	$ 647,661	$287,776	$100,642	$ 686	$2,437
NOTES RECEIVABLE FROM UNCONSOLIDATED SUBSIDIARIES, less current portion	421,500					421
LONG-TERM INVESTMENTS (Notes A and B)		151,349		18,626	710,072	880
INVESTMENT IN UNCONSOLIDATED SUBSIDIARIES (Note A)	1,200	645,533				646
PROPERTY AND EQUIPMENT (Notes A, C, and D)	2,220,138	122,612				2,342
	$4,043,183	$1,567,155	$287,776	$119,268	$710,758	$6,728

LIABILITIES AND FUND BALANCES	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Tota
CURRENT LIABILITIES:						
Accounts payable (Note F):						
American Medical Association	$ 104,500					$ 104
County medical societies	61,059					61,
Unconsolidated subsidiaries	7,241					7,
Michigan Doctors Political Action Committee	7,620					7,
Trade	176,104					176,
Accrued liabilities	59,060					59,
Prepaid dues	124,051					124,
Current portion of long-term debt (Note D)	25,938					25,
TOTAL CURRENT LIABILITIES	$ 565,573	$ -0-	$ -0-	$ -0-	$ -0-	$ 565,
LOSSES OF UNCONSOLIDATED SUBSIDIARIES IN EXCESS OF INVESTMENTS (Note A)			$352,721			352,
LONG-TERM DEBT, less current portion (Note D)	1,415,415					1,415,
FUND BALANCES (DEFICIT)	2,062,195	$1,567,155	(64,945)	$119,268	$710,758	4,394,
	$4,043,183	$1,567,155	$287,776	$119,268	$710,758	$6,728,

STATEMENT OF REVENUES AND EXPENSES

higan State Medical Society **November 30, 1988**

	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
ENUES:						
es – membership	$2,950,342					$2,950,342
idends and interest	193,753	$ 44,545	$ 33,635	$ 6,159	$75,895	353,987
chigan Medicine Magazine:						
dvertising	140,845					140,845
ubscriptions	24,492					24,492
nual scientific meeting:						
ourse revenue	66,442					66,442
xhibit sales	52,150					52,150
mputer and production services	71,522					71,522
nferences	65,228					65,228
es collection fees (Note F)	23,224					23,224
in on sale of investments (Note A)		27,399	25,013	2,280		54,692
tomobile rental income		30,297				30,297
covery of unrealized loss on marketable securities (Note B)		80,122				80,122
ntal income (Note G)	334,608	5,339				339,947
her (Note G)	513,770	7,370				521,140
	$4,436,376	$195,072	$ 58,648	$ 8,439	$75,895	$4,774,430
ENSES:						
fice of the Director	$ 944,225		$ 18,000			$ 962,225
ministration and physician education	481,118	$ 6,408	6,792			494,318
mmunications and professional relations	608,300					608,300
ance, medical economics, and physician hospital relations	615,487					615,487
vernment relations and membership development	593,697					593,697
ations and meeting planning	1,080,559	41,678				1,122,237
	$4,323,386	$ 48,086	$ 24,792	–0–	–0–	$4,396,264
REVENUES OVER EXPENSES BEFORE NET INCOME (LOSS) OF UNCONSOLIDATED SUBSIDIARIES	$ 112,990	$146,986	$ 33,856	$ 8,439	$75,895	$ 378,166
INCOME (LOSS) OF UNCONSOLIDATED BSIDIARIES (Note A)		(17,131)	68,841			51,710
REVENUES OVER EXPENSES	$ 112,990	$129,855	$102,697	$ 8,439	$75,895	$ 429,876

We have audited the accompanying balance sheet of Michigan State Medical Society as of November 30, 1988, and the related statements of revenues and expenses, changes in fund balances, and cash flows for the year then ended. These financial statements are the responsibility of the Society's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

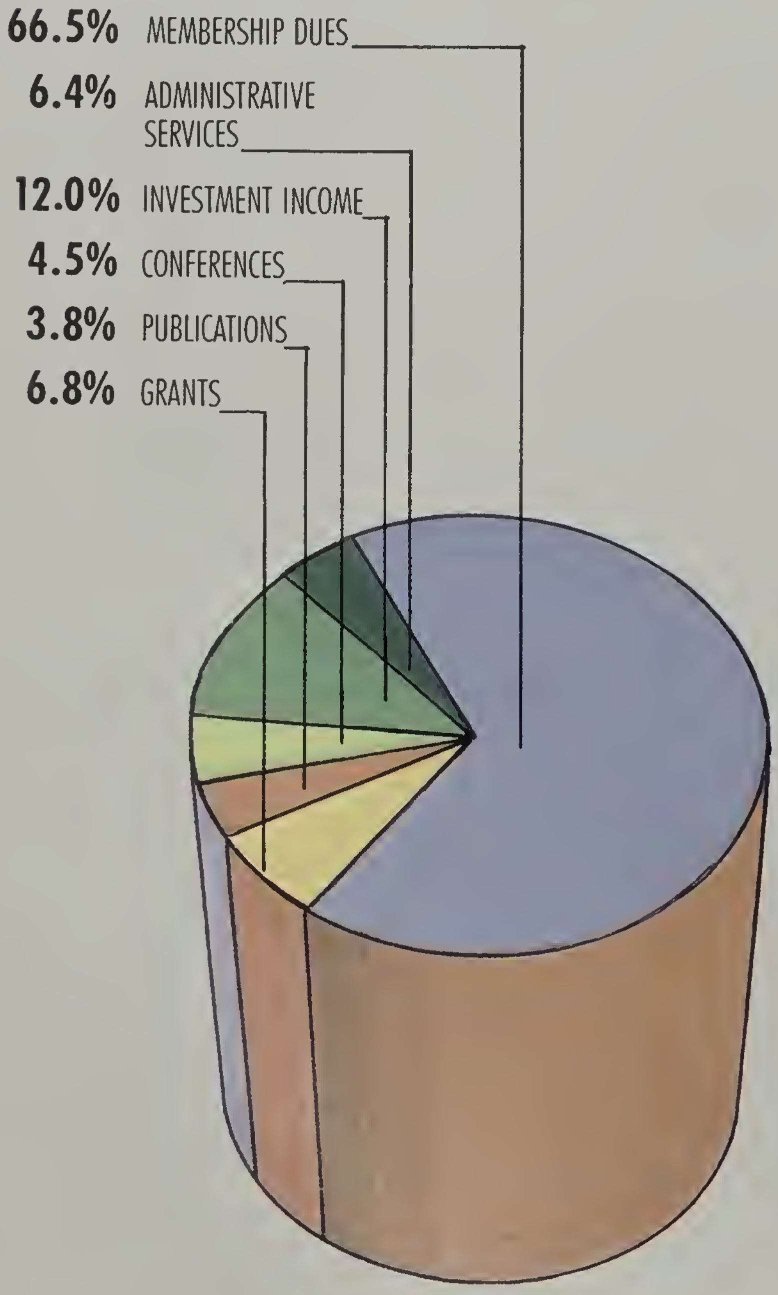
In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Michigan State Medical Society as of November 30, 1988, and the results of its operations and its cash flows for the year then ended in conformity with generally accepted accounting principles.

Touche Ross & Co

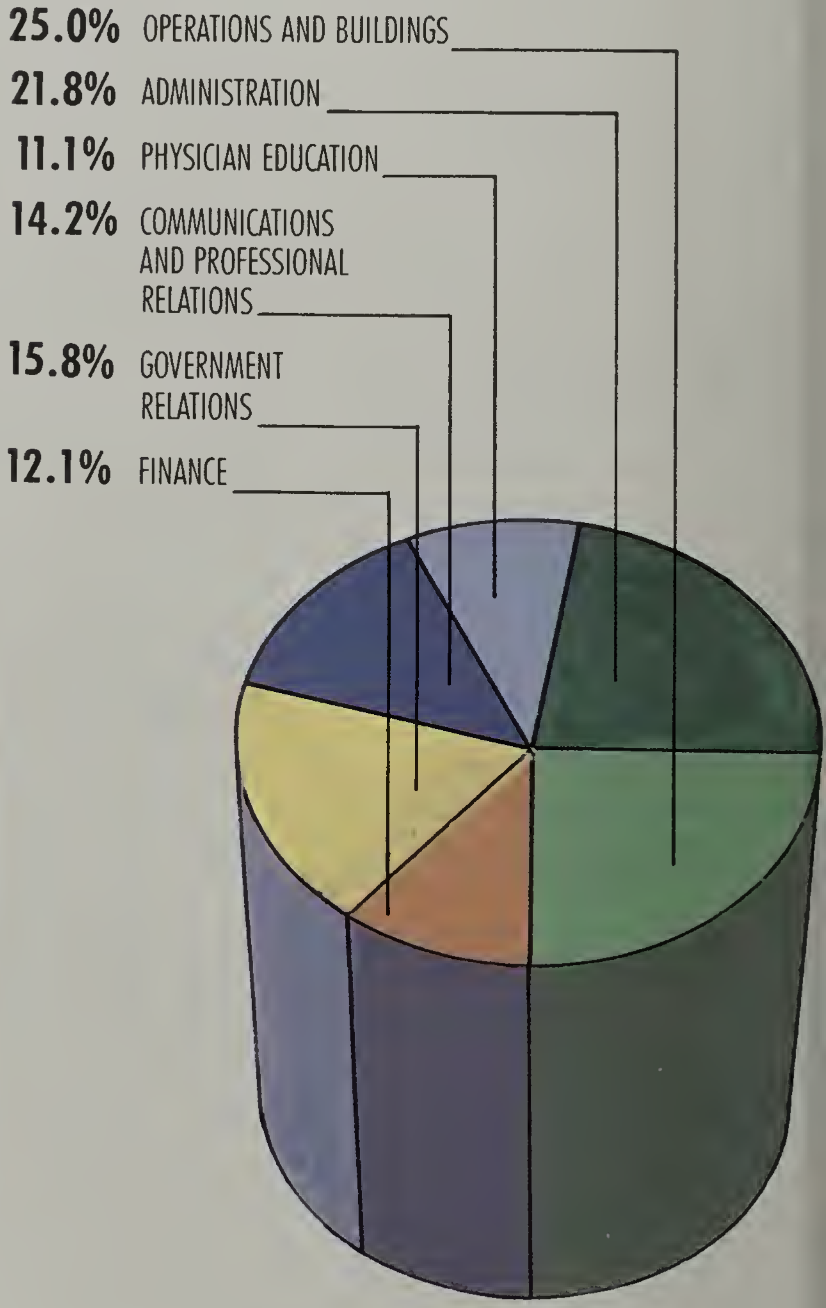
Certified Public Accountants
January 27, 1989

*Notes to financial statement are not included.

1988 OPERATING INCOME



1988 OPERATING EXPENSES



Whom To Call At MSMS Headquarters

Executive Director: William E. Madigan
Assistant Director: Kevin A. Kelly

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Betty McNerney
AMA Delegation	Sherry Wellman
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Mary Anne Ford
Auto Lease Plan	Richard Campau
Blue Cross Blue Shield/Third Party Payors	Robert Ortwein
Board of Medicine	Dan Farhat
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (in *Michigan Medicine*)	Sherry Fent
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Financial Operations	Richard Campau
Graduate Medical Education	Sherry Fent
Group Health Insurance Plan	Barb Zimmerman
Health Education Foundation	Vada Davis
HMOs/PPOs	Robert Ortwein
Hospital Medical Staff Relations	Tom Plasman
Judicial Commission	Katie Brewbaker
Legislation	Kevin Kelly, Dan Farhat
Maternal Health Conference	Sherry Fent
Media Relations	David Fox
Medicaid	Mary Anne Ford
Medical Assistants	Caroline Kimmel
Medical Ethics	Katie Brewbaker
Medicare	Robert Ortwein, Rose Heald
Medigram	Judy Marr
Member Benefits (Including insurance programs)	Richard Campau
Membership Records	Peg Berry
Membership Recruitment	Deborah Zannoth
Michigan Allergy Society	Viola Heins
Michigan Association of Medical Education	Viola Heins
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medicine (MSMS Journal)	Judy Marr, Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
Michigan Society of Internal Medicine	Caroline Kimmel
Michigan Society of General Surgeons	Caroline Kimmel
Michigan Society of Pathologists	Viola Heins
Michigan Society of Respiratory Therapy	Caroline Kimmel
MSMS Auxiliary	Viola Heins
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	Richard Campau
MSMS Meeting Facilities	Linda Munson
MSMS Travel Programs	Donna Farougi
Physicians Recovery Network	Katie Brewbaker
Physicians' Review Organization of Michigan, Inc. (PROM)	John Richards, Barbara Banks, RN
Physician Legislative Network	Dan Farhat
Physician Service Group, Inc.	John Richards
Practice Management	John Richards, Amy Fistler
Professional Liability Insurance	Richard Campau
Public Health Liaison	Mary Anne Ford
Public Relations	Sherry Wellman
Risk Management	Richard Campau
Specialty Societies	Donna Farougi

MICHIGAN STATE MEDICAL SOCIETY
120 W. SAGINAW ST., BOX 950
EAST LANSING, MI 48826-0950
517/337-1351

These products should not be written on triplicate prescription forms but must have the quantity identified in both written and numeric form.

Cooperation is vital

The implementation of the triplicate prescription program will have a major impact on the physicians and pharmacists of this state. The triplicate prescription law is very specific on what information must be provided by the physician and what must be provided by the pharmacist. The goal of the health care team is to provide timely and quality health care. Physicians and pharmacists must work together to guarantee that patient care does not suffer as a result of additional administrative requirements. Questions regarding the triplicate prescription program should be referred to the Triplicate Prescription Program, Bureau of Health Services, Department of Licensing and Regulation, P. O. Box 30202, Lansing, MI 48909; or call 1-800-366-TRIP. ■

Larry Wagenknecht is executive director of the Michigan Pharmacists Association.

Table 1
Schedule II Drugs Requiring Use Of Triplicate Rx Form*

Generic Name	*Brand Name*	*Dosage Form*
Amobarbital	(Amytal)	Cap,Tab,Inj,Pwd
Amphetamine		Tab
Cocaine		Liq,Tab,Inj
Codeine		Inj,Tab
Dextroamphetamine	(Dexedrine Spansule, Ferndex)	Cap,Tab
Dronabinol	(Marinol)	Cap
Ethylmorphine	(Dionin)	Pwd
Fentanyl		Inj
Fentanyl/Droperidol	(Innovar)	Inj
Hydromorphone	(Dilaudid)	Inj,Pwd,Supp,Tab
Levorphanol	(Levo-Dromoran)	Inj,Tab
Meperidine	(Demerol)	Tab,Inj,Cap,Liq
Meperidine/Acetaminophen	(Demerol APAP)	Tab
Meperidine/Promethazine	(Mepergan Fortis, Mepergan)	Cap,Inj
Methadone	(Dolophine)	Tab,Inj,Liq
Methamphetamine	(Desoxyn)	Tab
Methyphenidate	(Ritalin)	Tab
Morphine Sulfate/Atrophine		Inj,Tab
Morphine Sulfate	(Roxanol SR, RMS, Duramorph)	Tab,Supp,Inj,Liq
Nabilone	(Cesamet)	Cap
Opium Alkaloids	(Pantopon)	Inj
Opium Tincture		Liq
Opium and Belladonna		Supp
Oxycodone		Liq,Tab
Oxycodone/ASA	(Percodan)	Tab
Oxycodone/Acetaminophen	(Percocet, Tylox, Roxicet)	Tab,Cap,Liq
Oxycodone/Hexabarbital	(Percobarb)	Cap
Oxymorphone	(Numorphan)	Inj,Supp
Pentobarbital	(Nembutal)	Cap
Pentobarbital/Pentobarb	(Penotal)	Cap,Liq
Phenmetrazine	(Preludin)	Tab
Secob/Phenob/Butabarb	(Tri-Barbs, S.B.P.)	Cap,Tab
Secobarbital	(Seconal)	Cap,Tab,Inj
Secobarbital/Amobarbital	(Tuinal)	Cap
Sufentanil	(Sufenta)	Inj

* *This listing is not inclusive of all Schedule II drugs available on the market.*

Table 2
Commonly Prescribed Drugs **NOT** Requiring Triplicate Rx Form*

Acetaminophen/Codeine
Aspirin/Codeine
Ativan
Chloral Hydrate
Chlordiazepoxide
Dalmane
Darvocet N100
Darvon
Diazepan
Doriden
Halcion
Ionamin
Placidyl
Restoril
Talwin
Tenuate
Tepanil Ten-Tab
Viodin
Xanax

* *The commonly prescribed drugs in above list are Schedule III and IV controlled substances. The list is not inclusive of all Schedule III and IV controlled substances on the market.*

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

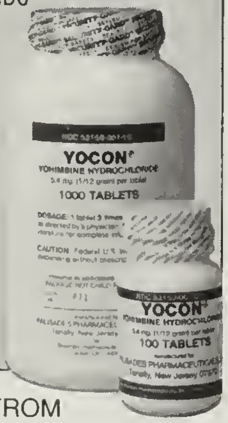
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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DEATHS

John K. Altland, MD
Lansing

Doctor Altland, a retired public health director, died May 25, 1989. He was 86. Doctor Altland was a graduate of the University of Michigan and served his medical internship at St. Mary's Hospital in Grand Rapids. He worked in private medical practice, military medicine during WWII and the state government. Doctor Altland served as the health commissioner with the state's Public Health Department and as the deputy director of public health. He became director of the Department of Social Services in 1966 and was instrumental in the development of Michigan's Medicaid program.

William G. Bentley, MD
Detroit

Doctor Bentley, a specialist in obstetrics and gynecology, died May 11, 1989. He was 62. Doctor Bentley received his bachelor of arts degree from Wayne State University, received medical training in Nashville, and then served his residency at Sinai Hospital in Detroit. Doctor Bentley established a joint medical practice in the early 1950s. He was also on staff at Hutzel, Harper-Grace, and St. Joseph Mercy hospitals during his medical career. Doctor Bentley was a member of the Wayne County Medical Society, the American College of Obstetrics and Gynecology, and the NAACP.

Ethel Calhoun, MD
Galesburg, Illinois

Doctor Calhoun, a retired general practitioner formerly of Westland, died May 22 in Galesburg, IL. She was 91. Doctor Calhoun received her medical degree from the University of Michigan. She established a private practice associated with the Sister Kenny Foundation in 1946 for the treatment of polio. In 1967 she received a presidential citation for meritorious service. Doctor Calhoun was named "Woman of the Year" by the Altrusa Club of Birmingham and became a member of the University of Michigan Emeritus Club for 50 years of medical practice. She retired in 1978. She was inducted into the Michigan Women's Hall of Fame in 1987.

John P. Clune, MD
Florida

Doctor Clune, a former Detroit ophthalmologist, died June 11. He was 55. In 1959, Doctor Clune graduated from Georgetown University in New York. He then went to Detroit for his internship at Detroit General Hospital and his residency at Kresge Eye Institute. Doctor Clune served in the US Navy achieving the rank of Commander during Vietnam. He was a member of the American Academy of Ophthalmology, American College of Surgeons, Michigan State Medical Society, Wayne County Medical Society, Michigan Ophthalmological Society, Medical Eye Services of Michigan, and the Detroit Ophthalmology Club.

Leon B. Cowen, MD
Detroit

Doctor Cowen, a Detroit urologist, died May 13 at the age of 96. He graduated from the University of Michigan Medical School in 1917. For the next two years he served as an Army captain during World War I and then began a medical practice in Detroit. He retired in 1968 and joined the International Red Cross medical service. At age 80, he served in Africa for more than a year during the Biafran War. Later, he established a medical practice on the Wounded Knee Indian Reservation at South Dakota and accompanied horseback expeditions over the Rocky Mountains.

Roy E. Craig, MD
Grosse Pointe

Doctor Craig, a general practitioner, died June 2. He was an infantry officer in World War II and had graduated in 1955 from the Wayne State University School of Medicine. Doctor Craig practiced medicine until 1985 when he retired from Cottage Hospital. He was a member of the Michigan State Medical Society, the American Academy of Family Practice, and the Wayne County Medical Society.

J. J. MacNeil, MD
Birmingham

Doctor MacNeil, an orthopedic surgeon, died May 23. He was 73. Doctor MacNeil attended medical school at St. Francis Xavier, Antigonish, Nova Scotia, and received his medical degree from King's College at Cambridge University in England. He served his internship at the London University Hospital. Doctor MacNeil had private practices in Rochester and Birmingham for 25 years. He also was on staff at Crittenton Hospital in Rochester. Doctor MacNeil was a member of the American Medical Association, the Oakland County Medical Association, Royal College of Surgeons, and the England Academy of Medicine-Orthopedic in Toronto.

Richard L. Orders, MD
Grand Rapids

Doctor Orders, a dermatologist, died June 4. He was 60. Doctor Orders received his medical training at Ohio State University College. He was a member of the Kent County Medical Society, Michigan State Medical Society, and the American Academy of Dermatology.

LeMoyne Snyder, MD
California

Doctor Snyder, a doctor and lawyer, died May 27 at the age of 90. He graduated from Michigan State University in 1919. He also attended University of Michigan Medical School and Harvard Medical School. Doctor Snyder was appointed medical-legal director for the Michigan State Police in the late 1930s and held that position until he moved to California. He founded the Department of Police Administration at MSU and the Michigan Crime Laboratory. In the 1950s he also helped to establish the Court of Last Resort to help free Americans who were imprisoned unjustly.

William A. Summers, MD
Grosse Pointe Shores

Doctor Summers, an ear, nose, and throat specialist, died May 17. He was a 1940 graduate of Wayne State University. He conducted his residency at Harper Hospital in Detroit. He was a captain in the US Army medical corps for two years and then established a private practice. Doctor Summers retired in 1977. He was a member of the Michigan State Medical Society, the American Medical Association, and the Wayne County Medical Society.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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5333 McAuley Drive R2010
Ypsilanti 48197

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6689 Ridgefield Cir. #702
West Bloomfield 48322

Mohammed N. Amin, MD — PD
5885 M-15
Clarkston 48016

Charles A. Andrews, MD — IM
1000 E. Paris, SE #215
Grand Rapids 49506

Glenn D. Bauer, MD — PD
6600 Highland Road
Pontiac 48054

Abbas Bekhrad, MD — U
3406 Davenport
Saginaw 48602

Sosale M. Berkuchel, MD — U
38 S. Elk Street
Sandusky 48471

John G. Bizon, MD — OTO
16 E. Emmett #1
Battle Creek 49017

Donald F. Bosker, MD — GP
1198 N. Belsay Road
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David B. Bosscher, DO — FP
4005 Orchard Drive
Midland 48640

Glen A. Chamulak, MD — CLP/HEM
302 Kensington
Flint 48502

Sai B. Chundu, MD — P
911 Village Green Ln. #1060-6
Pontiac 48054

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420 W. Magnetic
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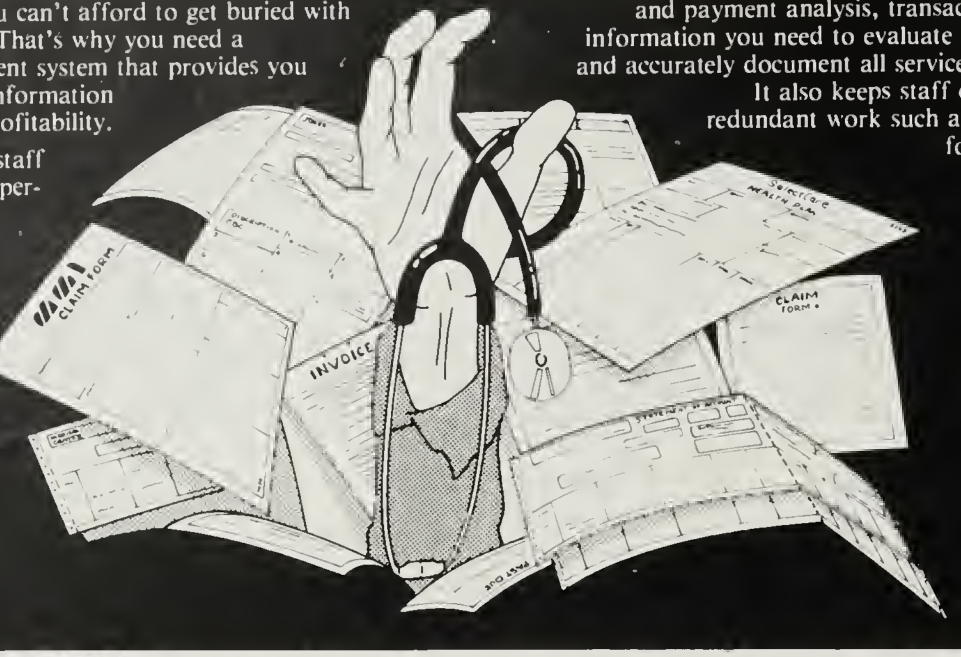

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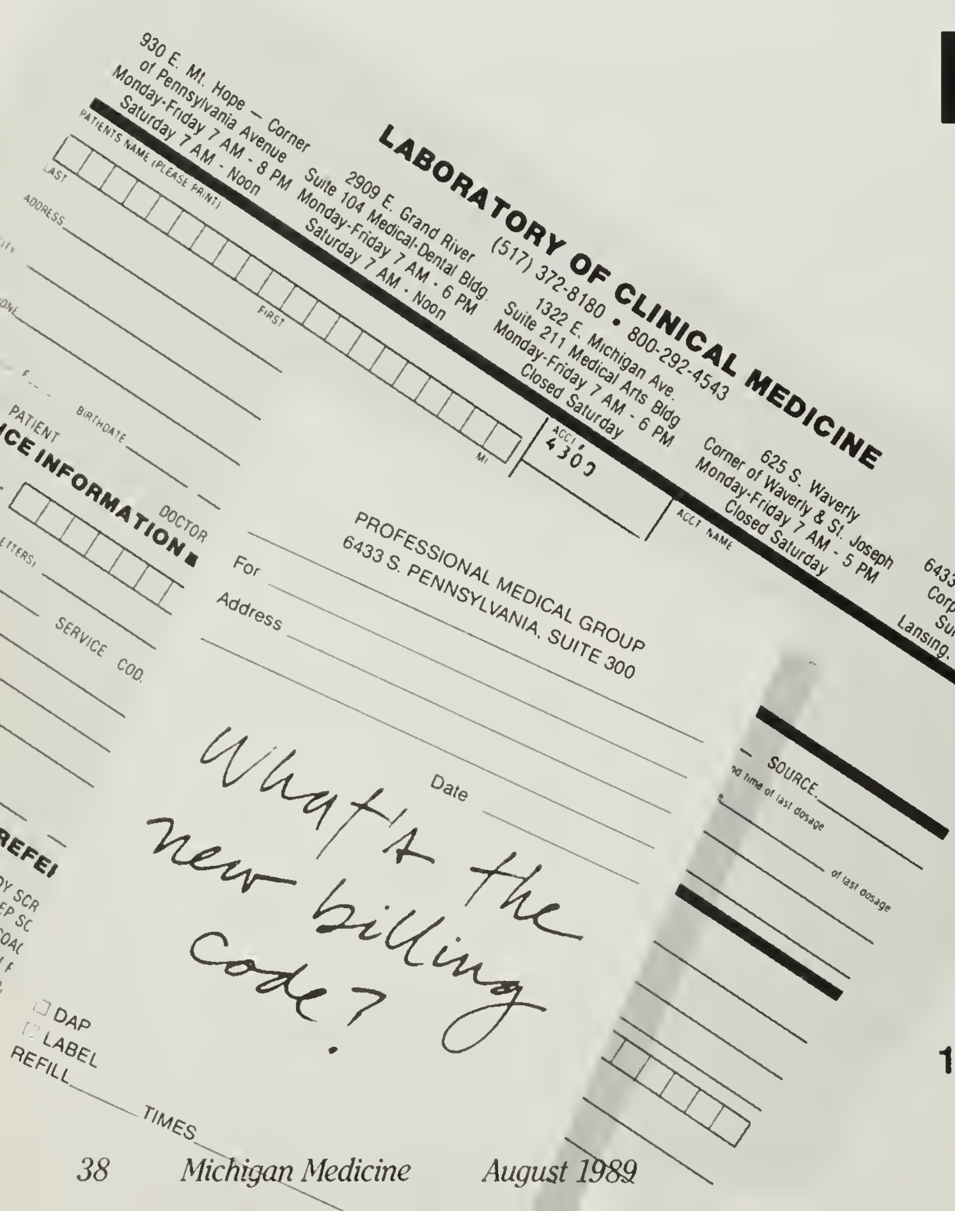

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

August

24-26, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort Village, Grand Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

25-27, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

September

7-8, The Practice of Clinical Nutrition: Science & Application for the Future. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763- 1400. **Approved for:** 10 hours Category I Credit.

11-12, Epilepsy Advances. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

11-16, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School; Michigan Association of Pediatric Directors, Michigan Chapter; American Academy of Pediatrics. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 936-9800. **Approved for:** 55 hours Category I Credit.

13, Update: Medical Management & Treatment of Arthridities. Location: Southfield Hotel & Conference Center. **Contact:** Shelley L. Helton, CME/Program Assistant, Henry Ford Hospital Office of Medical Education, 2799 W. Grand Blvd., Detroit, Michigan 48202-2689 (313) 876-3073. **Approved for:** 4 hours Category I Credit.

14-16, Recent Trends in Clinical Electrophysiology: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

15-16, Recent Trends in Electrophysiologic Assessment: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

21-23, The National Conference on Pediatric Trauma. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** Kiqanis Pediatric Trauma Institute, New England Medical Center, University of Michigan Medical School, General Motors Corp., **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

21-24, 34th Annual ACP-Michigan Chapter/MSIM Regional Meeting. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** American College of Physicians, Michigan Chapter and the Michigan Society of Internal Medicine. **Contact:** Patrick C. Alguire, MD, FACP, Department of Medicine, Michigan State University, B-301 Clinical Center, East Lansing, MI 48824. (517) 353-5100. **Approved for:** 18.5 hours Category I Credit.

28-30, Advanced Concepts in Total Hip & Total Knee Revision Surgery. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, CME/Program Assistant, Office of Medical Education, 2799 W. Grand Blvd., Detroit, Michigan 48202-2689 (313) 876-3073. **Approved for:** 16 hours Category I Credit.

October

2-3, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

4-6, A Symposium on Neonatal Respiratory Disorders. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

5-7, 12th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201,

Continued on page 40

CATEGORY I COURSES

Continued from previous page

University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 16 hours Category I Credit.

12-13, Office Procedures for Primary Care Physicians. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

12-14, 20th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids, Michigan. **Sponsors:** MSU College of Human Medicine, International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Bldg., 1900 Wealthy S.E., Suite #290, Grand Rapids, MI 49506 (616) 774-0440. **Approved for:** 18 hours Category I Credit.

18, Pediatric Urology for the Practitioner. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial and Behavioral Issues. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. **Approved for:** 13 hours Category I Credit.

20-21, Psychiatry Update 1989 – A Tribute to Raymond W. Waggoner, MD. Location: The Michigan Inn, Southfield, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 12 hours Category I Credit.

25-28, Midwest Addictions Conference. Location: Detroit Radisson Hotel, Detroit Airport. **Sponsors:** Samaritan Health Center, American Medical Society on Alcoholism and Other Drug Dependencies, Western Michigan Addictionology Consultants, Inc., Michigan Psychological Association. **Contact:** Diane Campbell, Samaritan Health Center, 5555 Conner Ave., Detroit, MI 48213 (313) 579-4925. **Approved for:** 26 hours Category I Credit.

26-27, Critical Care Issues in the Care of the Elderly. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Geriatric Medicine, Department of Internal Medicine VAMC. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

November

2-4, Modern Perinatal Problems: An Update for the Practicing Obstetrician-Gynecologist. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

13-14, 8th Annual Michigan Statewide Conference on Child Abuse and Neglect: Child Abuse and Substance Abuse. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, University of Michigan Child Protection Team. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

18, EveryDoc's Pediatric Dermatology. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Department of Dermatology. **Contact:** Diane Davis, Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202. (313) 876-3073 or 800-888-4340. **Approved for:** 4.5 Category I Credit.

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Conference On

"DIAGNOSIS AND MANAGEMENT OF BREAST CANCER"

Organized by
MICHIGAN CANCER FOUNDATION
Sponsored by
Michigan State Medical Society
and the
Meyer L. Prentis
Comprehensive Cancer Center of Metropolitan Detroit

WEDNESDAY, NOVEMBER 22, 1989

OBJECTIVES

1. To provide an update on new developments in diagnosis of breast cancer.
2. To increase skills in the use and interpretation of diagnostic tools in the prognosis of breast cancer.
3. To update current knowledge on the use of adjuvant chemotherapy.
4. To critique current uses of chemotherapy in breast cancer.

CONFERENCE DESCRIPTION

This in depth program is designed for practicing oncologists, pathologists, surgeons, residents and fellows as well as basic researchers to review current knowledge in diagnosis and management of breast cancer. The meeting will be limited to 300 participants who will be accomodated on a first come first served basis. The conference will be held at the Engineering Society of Detroit, 100 Farnsworth, Detroit, MI 48202. This conference is partially supported by the Suzanne Korman Morton Cancer Research Fund and Warner-Lambert/Parke-Davis.

SCHEDULED SPEAKERS

"The Need of Predictors for Breast Cancer", **Michael J. Brennan, M.D.,** Michigan Cancer Foundation, Detroit, MI; "The New and the Old in Breast Cancer Diagnosis", **Leopold Koss, M.D.,** Montefiore Medical Center, New York, NY; "Morphological Basis of Breast Cancer Prognosis" **Jose Russo, M.D., Conference Director,** Michigan Cancer Foundation, Detroit, MI; "The MCF Experience in Breast Cancer Prognosis", **Helen Ownby, Ph.D.,** Michigan Cancer Foundation, Detroit, MI; "The Comorbidity Factor in the Decision Process of Adjuvant Chemotherapy", **William Satariano, Ph.D.,** University of California, Berkeley, CA; A Critical Assessment of Adjuvant Therapy for Breast Cancer", **John H. Glick, M.D.,** University of Pennsylvania, Philadelphia, PA; "The Use of Prognostic Factors in the Selection of Therapy for Patients with Early Breast Cancer", **I.Craig Henderson, M.D.,** Dana-Farber Cancer Institute, Boston, MA; **PANEL DISCUSSION: Panel Members: L. Baker, D.O. (Chairperson), M.J. Brennan, M.D.; J.H. Glick, M.D.; I.C. Henderson, M.D.; L. Koss, M.D.; S. Martino, D.O.; H. Ownby, Ph.D.; J. Russo, M.D.; W. Satariano, Ph.D.; G. Wilson, M.D.**

TUITION

The registration fee is $75 for professionals and $25 for residents and fellows. The fee includes coffee breaks and lunch. Due to the expected number of participants for this conference, early registration is highly advised. Residents and Fellows must provide a letter from their program director or supervisor certifying their status. In the event of cancellation, the fee will be refunded in full if notification is received two weeks prior to the initiation of this conference. All registration fees should be in US currency and submitted with registration forms. All checks should be made payable to the Michigan Cancer Foundation.

CONTINUING MEDICAL EDUCATION CREDIT

The Michigan State Medical Society Committee on Continued Medical Education Accreditation, designates this activity meets the criteria for a maximum of 6.5 credit hours in Category I towards the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed.

REGISTRATION INFORMATION

For additional information call or write to Ms. Kathy Dauphinais (313) 833-0710, ext: 362 or Ms. Vivian Powell (313) 833-0710, ext: 219, Michigan Cancer Foundation, 110 East Warren Avenue, Detroit, MI 48201.

MEETINGS

MSMS Meetings

September

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

26, MSMS Public Affairs/Leadership Conference, Lansing Radisson, Lansing, Michigan, Contact: Mary Anne Ford, MSMS Chief, State Government Affairs, (517) 337-1351.

November

7-9, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn. Contact: Sherry L. Fent, Chief of Physician Education (517) 337-1351.

AMA Meetings

October

2-3, Eighth Annual AMA Science Reporters Conference, Marriott Medical Center Hotel, Houston, Texas, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610. (312) 645-4417.

Michigan Specialty Society Meetings

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633.

National Specialty Society Meetings

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601. (312) 644- 6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091. (703) 648-8900.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact; American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911. (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact:

lanta, GA, Contact: American Society of Hematology, 6900 Grove Road, Thorofare, NJ 08086. (609) 845-0003.

2-7, American Academy of Dermatology Annual Meeting, San Francisco, CA, Contact: American Academy of Dermatology, 1567 Maple Avenue, P. O. Box 3116, Evanston, IL 60204-3116. (312) 869-3954.

Other Meetings

September

11-13, Treatment of Destructive Behaviors in Persons with Developmental Disabilities, Warren Grant Magnuson Clinical Center, Bethesda, Maryland 20852. (301) 468-6555. American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114. (816) 333-9700.

21-23, American College of Nuclear Medicine Scientific Meeting, Swiss Grand, Chicago, IL. Contact: American College of Nuclear Medicine, Box 5887, Columbus, GA 31906. (404) 322-8049.

21-24, American College of Nuclear Physicians Interim Meeting, Loews L'Enfant Plaza Hotel, Washington, DC. Contact: American College of Nuclear Physicians, 1101 Connecticut Ave., NW, Ste. 700, Washington, DC 20036. (202) 857-1135.

24-27, American Neurological Association, New Orleans, Contact; American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414. (612) 378-3290.

24-28, American Academy of Otolaryngology — Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology — Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005. (202) 239-4607.

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016. (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068. (312) 825-5586.

15-20, American College of Surgeons Annual Scientific Meeting, Atlanta Hilton and Towers, Atlanta, GA, Contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611. (312) 664-4050.

19-22, American Society of Internal Medicine Annual Meeting, J.W. Marriott, Washington, DC, Contact: American Society of Internal Medicine, 1101 Vermont Avenue, N.W., Suite 500, Washington, DC 20005. (202) 289-1700.

21-25, American College of Gastroenterology Scientific Meeting, Marriott Hotel, New Orleans, LA, Contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944. (617) 927-8330.

21-26, American Academy of Pediatrics Annual Meeting, Chicago, IL, Contact: American Academy of Pediatrics, 141 Northwest Point Road, P. O. Box 927, Elk Grove Village, IL 60007. (312) 288-5005.

23-25, American College of Gastroenterology Annual Meeting, Marriott Hotel, New Orleans, LA. Contact: American College of Gastroenterology, 13 Elm St., Manchester, MA 01944. (617) 927-8330.

28-11/3, American Society of Clinical Pathologists Annual Scientific Meeting, Ramada Renaissance, Washington, DC, Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612. (312) 738-1336.

28-11/3, College of American Pathologists Annual Scientific Meeting, Washington Ramada, Washington, DC, Contact; College of American Pathologists, 5202 Old Orchard Road, Skokie, IL 60077. (312) 966-5700.

29-11/2, American Academy of Ophthalmology Annual Meeting, Convention Center, New Orleans, LA, Contact: American Academy of Ophthalmology, P. O. Box 7424, 655 Beach, San Francisco, CA 94120. (415) 561-8500.

29-11/3, American Society of Plastic and Reconstructive Surgeons Annual Scientific Meeting, San Francisco Hilton, San Francisco, CA, Contact: American Society of Plastic and Reconstructive Surgeons, 233 N. Michigan Avenue, Suite 1900, Chicago, IL 60601. (312) 856-1818.

29-11/4, Congress of Neurological Surgeons Annual Meeting, Atlanta, GA, Contact: Congress of Neurological Surgeons, University of Southern California, 1200 N. State Street, Los Angeles, CA 90033. (213) 226-7421.

30-11/3, American College of Chest Physicians, Annual Meeting, Sheraton/Weston, Boston MA. Contact: American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. (312) 698-2200.

30-11/3, American Academy of Occupational Medicine Interim Meeting, Sheraton

Inner Harbor, Baltimore, MD. Contact: American Academy of Occupational Medicine, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005. (312) 228-6850.

November

3-4, American Academy of Pain Medicine, 1989 Annual Conference, Dallas, TX, Contact: American Academy of Pain Medicine, 43 East Ohio #914, Chicago, IL 60611. (312) 645-0083.

5-10, American Academy of Physical Medicine and Rehabilitation, Convention Center, San Antonio, TX, Contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603-6107. (312) 922-9366.

11-15, American College of Allergy and Immunology, Orlando, FL, Contact: American College of Allergy and Immunology, 800 E. Northwest Highway #1080, Palatine, IL 60067. (312) 359-2800.

13-16, American Heart Association, New Orleans, LA, Contact: American Heart Association, 7320 Greenville Avenue, Dallas, TX 75231. (214) 706-1483.

December

2-5, American Society of Hematology, Atlanta, GA, Contact: American Society of Hematology, 6900 Grove Road, Thorofare, NJ 08086 (609) 845-0003.

2-7, American Academy of Dermatology Annual Meeting, San Francisco, CA, Contact: American Academy of Dermatology, 1567 Maple Avenue, P. O. Box 3116, Evanston, IL 60204-3116 (312) 869-3954.

Other Meetings

September

11-13, Treatment of Destructive Behaviors in Persons with Developmental Disabilities, Warren Grant Magnuson Clinical Center, Bethesda, Maryland. Rockville pike, Rockville, Maryland 20852. (301) 468-6555.

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GENERAL INTERNIST: Marshfield Clinic, a multispecialty group practice with over 300 physicians, is seeking BE/BC general internists to join expanding regional centers. Practice opportunities range in size from multispecialty groups of 11 to 25. Positions available in three locations. One in northwestern Wisconsin, 90 miles from Minneapolis; one in north central Wisconsin in close proximity to the U. P. of Michigan and Lake Superior; and one in central Wisconsin within 35 miles of Marshfield. Full specialty consultation readily available. Positions offer strong economic stability combined with exceptional recreational, cultural, and educational opportunities. Starting salary up to $89,400 with salary in two years up to $113,100. Fringe benefit package is outstanding. Send CV and references to: David L. Draves, Director Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

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Continued on page 46

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Continued from previous page

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PRESIDENT'S PAGE

Member Interest and Involvement are Vitally Important

By Robert E. Paxton, MD

Increased membership involvement — in organized medicine and in politics — is among the top three goals of my presidency. The other two goals are unity and the pursuit of realistic solutions to some of our problems, particularly the professional liability crisis.

As we wind down from vacations and look forward to another busy season, I feel it is particularly appropriate — and vitally important — to discuss the need for member involvement.

Effective involvement requires dedication. Dedication directed towards our profession and service to our patients. This involvement takes on several facets of activity that place demands on our time. The political process and organized medicine are two such demands on which I particularly want to concentrate. It is my hope that this president's page will stimulate you to consider the responsibility your profession places on you, and to examine your priorities.

At the onset I admit that, in addition to our practices, we must allocate time for family, religion, community commitment, and of course, personal recreation and relaxation. But in this complex picture of activity, one must sort out the priorities and effectively allocate time. It seems as if the old adage still holds true: "If you want something done, ask a busy person to do it!"

First of all, what about the political process? Characteristically, physicians do not want to get involved in politics. It has always been thought of as something "dirty" and beneath our profession. We remained aloof while we were secluded in our ivory tower practicing medicine in an idealistic providers dream world. I would not argue with this perception except to point out that "it ain't so" anymore.

Politics is the way a democracy functions. It is the process we utilize to initiate change or to resist undesirable change. Economists, industrialists, sociologists, bureaucrats, and others have partially succeeded in stripping the physician of his autonomy and his professionalism. This allows government and industry to better control health care and contain costs by rationing. Add to this problem the limited access for the 37 million uninsured, plus the malpractice crisis, and we begin to appreciate what we are up against in today's health care arena.

To cope with the realities of this new era, we must get politically involved. It will make a difference! "Ok," you ask me, "how do I get involved?"

The first step is to be a sustaining member of MDPAC. This small contribution does a lot more than gain us access to lawmakers and help fund the campaigns of our friends. A large PAC membership sends a very significant signal that doctors do care and intend to be involved.

The next step is personal involvement in the process. Contact your senators and representatives on a regular basis, as they know you and have confidence in you. It makes no difference whether they belong to the party of your choice or whether you voted for them. They represent you and it is your responsibility to confront them with medicine's needs and what is best for our patients. Remember this fact! Politicians do listen to MSMS lobbyists and your leaders, but they are more likely to act when they get pressure from the grass roots.

What about involvement in organized medicine? The current challenges to medical care are so formidable that we must present a unified front representing all of the profession. This way we can claim full representation and our efforts will be more effective.

We need 100 percent membership in MSMS. But our involvement cannot stop with membership alone. We must be active and involved in all levels of organized medicine. We must thoughtfully select our colleagues to represent us in higher offices and provide them with ongoing input. We must sustain a medical society that is vibrant and alive. Grass root interest and involvement is vital!

Let me go a step further. As I reflect on the meeting this past June of the AMA House of Delegates, I fail to comprehend why some physicians are not AMA members. We are witnessing a revolutionary change in the delivery of health care which is devastating for our patients and is demoralizing to our profession.

In Chicago, I saw in action the only hope for us and our patients – the AMA. The democratic form of this giant was evident everywhere. We confronted the formidable alliance between President Bush and Congressman "Pete" Stark on expenditure targets and our enthusiasm was not deterred. Among others, we wrestled with the problem of the uninsured, assault weapons, preventive health issues and bioethical dilemmas. I am convinced that the only organization capable of securing health care delivery for our country and our profession is the AMA.

Results of a recent poll indicate that 80 percent of the public is convinced that the AMA is a reliable source of medical knowledge. In addition, 90 percent said they feel it is important for their doctor to belong to the AMA. Well over 60 percent said they think their doctor is indeed an AMA member! From this we can readily see that there is a significant number of "free-loaders" who are enjoying the image of AMA membership without being involved. More important, the AMA is respected in Washington as the voice of medicine in this country. It is not fair that less than 50 percent of MDs in the nation support the AMA with membership while all benefit from it.

Finally, I have no patience with the physician who gives up and declares that the present environment is hopeless — that it is impossible to do anything about it. The world is moving so fast these days that the one who says it can't be done is generally interrupted by someone doing it.

Let's be the someone doing it! Get involved! Play an active role and make the democratic process work. We can and will do the impossible.

Doctor Paxton is MSMS president.

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MICHIGAN MEDICINE

Award-Winning Journal of the Michigan State Medical Society

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Cover Story

Now more than ever, risk prevention is assuming a significant role in the activity of organized medicine. As MSMS President Robert E. Paxton, MD, notes, "It is politically expedient for MSMS to demonstrate a keen interest in risk prevention. Legislators have to be convinced that we are addressing this aspect of professional liability before they will consider any further tort reform or tort alternatives." Risk prevention, indeed, is a timely subject; it represents an ever enlarging scope of activity for MSMS. Consequently, this month's cover story is dedicated to the topic. Included in the cover story is an introduction by MSMS President Paxton; two articles on risk prevention and liability insurance submitted by the Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM); excerpts of a speech given by AMA Senior Deputy Executive Vice President James Todd, MD, to members of the Physicians Insurers Association of America; a report on the success of anesthesiologists in establishing practice parameters; and a short report on the Society's plans to establish a Section on Risk Prevention.

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Cover illustration by: *Robert L. Brent.*

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IN MY OPINION

Risk Management: One Way to Control Escalating Liability Cost

By Gary D. Maynard, MD

This journal and other medical publications as well as national and state newspapers and magazines are expounding on methods to control escalating liability costs for physicians. These methods include various tort reforms and alternatives to the tort system. Besides legislative and judicial reforms to allay the liability crisis, physicians also must scrutinize themselves. Experience of the claims committees of the two physician-owned Michigan liability insurance companies suggests that, despite common physician beliefs, most lawsuits are not frivolous.

In 1984, the Harvard Medical School's Department of Anesthesia formed a formal risk management committee. Their purpose was to minimize anesthesia-related accidents, near-accidents, errors and untoward outcomes for patients anesthetized within their medical school system. The committee reviewed all closed and open anesthesia-related claim abstracts to determine patterns of care by anesthesia personnel. Results indicated that certain types of problems kept recurring.

Following the identification of these problems, the Risk Management Committee next sought to minimize them. The committee members developed minimum anesthesia standards which were published in *JAMA*, Aug. 22/29, 1986, Vol. 256, No. 8, pp. 1017-1020, entitled, "Standards for Patient Monitoring During Anesthesia at Harvard Medical School."

With minor adjustments, these standards were presented to the American Society of Anesthesiologists House of Delegates in October 1986 and nearly unanimously approved.

Based on these standards, at least three states lowered the liability risk classification of anesthesiologists and thereby decreased the cost of an anesthesiologist's liability coverage. Both physician-owned liability insurance companies in Michigan are offering risk management courses and are designating specific monitoring equipment to include pulse oximeters and capnographs to allow anesthesiologists further reduction in their rates.

Being proactive allowed anesthesiologists not only to reduce their cost of liability but more importantly, to deliver better patient care. Better patient care is the real issue. Setting standards or minimal guidelines is hotly debated at present. Many physicians fear the institutions of such standards will be set by non-clinicians such as the JCAHO, PROs or other regulatory bodies interested in controlling medicine. Given this scenario, many physicians feel it is better for the medical societies to develop standards or guidelines to insure proper physician input and emphasis on patient care.

The institution of minimal guidelines by the medical societies will provide better patient care. The use of guidelines can insure that minimal requirements will be provided to all patients. Minimum standards argue against "cookbook medicine," in that each individual physician may decide at which level of quality above the minimum he wishes to render care for his patients. This is as it should be. Standards or guidelines also can offer protection within the legal system. Known standards of care can be the best defense. Physicians as advocates for the good of patients must take a proactive role to insure quality patient care is rendered. ■

Doctor Maynard is a Kalamazoo anesthesiologist and is chairman of the MSMS Hospital Medical Staff Section.

Michigan State Medical Society's Physician Service Group, Inc. announces its 1989 Fall Seminar Schedule

Seminar Series	Date	Location
ICD-9 Coding Seminar	8-15-1989	Hilton Inn, Novi
(Conomikes Associates, Inc.)	8-16-1989	Amway Grand, Grand Rapids
	8-17-1989	Grand Traverse Resort Traverse City
Third Party Reimbursement and Coding	10-11-1989	Amway Grand, Grand Rapids
(Conomikes Associates, Inc.)	10-12-1989	Somerset Inn, Troy
Young Physicians	9-29-1989	Ford Hospital, Detroit
(Half-day, Kerr, Russell and Weber)		
Fostering Positive Physician/ Patient Relations	10-05-1989	Weber's Inn, Ann Arbor
Retirement Planning	10-18-1989	Weber's Inn, Ann Arbor
	10-19-1989	Amway Grand, Grand Rapids
Starting Yourself in Medical Practice	9-20-1989	Amway Grand, Grand Rapids
	10-25-1989	Dearborn Inn, Dearborn
AMA/MSMS Office Management Series	11-01-1989	Hyatt Regency, Dearborn
	11-02-1989	Hyatt Regency, Dearborn
	11-03-1989	Hyatt Regency, Dearborn
Medicare Series	11-14-1989	Dearborn Inn, Dearborn
(Conomikes Associates, Inc.)	11-15-1989	Holiday Inn, East Lansing
	11-16-1989	Amway Grand, Grand Rapids

Please contact Amy Fistler or Julie Morse for information, or to register for any of the above seminars. Address is Michigan State Medical Society, PO Box 950, East Lansing, MI 48826-0950. Telephone 517/337-1351.

Michigan Medicine Earns High Marks In Readership Survey

By Judy Marr, Editor

Michigan Medicine earned extremely high marks in a readership survey just completed by an independent Evanston, Ill., surveyor.

"Readership of *Michigan Medicine* among MSMS members is very high, with nearly 75 percent reporting that they read three out of four issues," reports surveyor Martin Block, PhD, formerly of Michigan State University.

"This high level of readership is especially noteworthy given the large number of magazines and journals that most MSMS members regularly receive," he continues.

According to his survey, Doctor Block says that readership is uniform across members' types of practice, community of practice, gender, marital status, those having children or not, and income.

Those under 40, however, were somewhat less likely to read the magazine than were older members.

The information came from a survey this summer of all MSMS members. Doctor Block mailed 11,952 questionnaires. A total of 4,217 were returned, for an effective completion rate of 35.3 percent. The surveyor had the input of 3,554 MSMS members in active practice.

The most-read section in *Michigan Medicine* is the cover story. Cover story topics in 1989 have included environmental health hazards, care of the elderly, access to medical care for the uninsured, MSMS House of Delegates actions, practice management for the 1990s, professional liability alternatives, and federal and state legislation.

The "Physicians in the News" column, the president's page, the "In My Opinion" and "Letters" columns round out the top five sections of the magazine in reader popularity, reports Doctor Block.

What topics would MSMS members like to have the magazine cover? Here is the list, in order of most frequent mention:

- Practice management
- Insurance coverage and rates
- Blues payment problems
- Malpractice
- Specialty topics
- Current issues
- Ethics
- Liability
- Scientific and clinical articles
- Government infringements
- Legal issues
- Money management
- Retirement
- MSMS political activity
- Economic issues
- Future of medicine
- Rural practice problems
- Medical history
- AIDS
- Lyme disease
- Reducing accelerating costs

"We are extremely pleased with *Michigan Medicine's* high readership marks," says Henry M. Domzalski, MD, chairman, MSMS Committee on Publications. "This demonstrates the magazine's vitality as an MSMS communications tool."

"This survey also reinforces findings of an East Coast firm which studied 10 state medical society journals in 1987. There is no doubt that we are well read.

"We will continue to strive to serve our MSMS membership well through our publications." ■

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Expanding Medicaid eligibility won't improve US infant mortality rates, study shows

The Bush administration's proposed expansion of eligibility for Medicaid benefits to pregnant women will have surprisingly little impact on infant mortality rates, according to a University of Michigan study.

"Although Medicaid eligibility requirements are so narrow that less than half of American women living below the poverty line are eligible for the program, our research indicates that simply expanding the program would almost have no significant impact on birth outcomes," says Lewis Margolis, assistant professor of public health policy and administration at the U-M School of Public Health.

Why?

"Although women on Medicaid have financial access to prenatal medical care, they make their first prenatal visit to a physician later and have fewer visits than women with medical insurance," Doctor Margolis says. "More surprisingly, they also make their first visits to obstetricians later than women with no insurance at all."

Medicaid recipients are more likely to drink and smoke than insured and uninsured women, according to the study. They also have lower incomes. Their infants' birth-weights are 200 grams lighter on the average than the other infants.

Doctor Margolis and his colleagues analyzed data from nearly 2,000 post-partum interviews conducted by the Michigan State Department of Health in 1983. The women in the study were either privately insured by Blue Cross or an equivalent program (63.7 percent of the women), completely uninsured (11.7) or on Medicaid (24.6).

The study concluded that, of all the groups, the women on Medicaid were at greatest risk for poor pregnancy outcomes, Doctor Margolis notes.

Nearly 97 percent of the women on Medicaid had annual incomes below $20,300 (the income ceiling for a family of four which determines eligibility for the supplemental nutrition program for high risk mothers and children). Sixty-five percent of the uninsured and 26 percent of the insured had incomes below $20,300.

Nearly half of the Medicaid recipients had not finished high school compared with 15.2 percent of those without insurance and 9.4 percent of the insured.

Although the Medicaid women were as likely to have had complete physical exams and ultrasounds as the insured women during pregnancy, they were more likely to report insufficient food and lack of nutritional counseling. They also were the least likely of the women to enroll in expectant parent classes.

Beaumont Hospital offers outpatient angioplasty for low risk patients

William Beaumont Hospital, Royal Oak, is taking a new approach to a well-established procedure for opening narrowed heart arteries.

Coronary balloon angioplasty, introduced more than 10 years ago as a major treatment for heart disease, is now being performed on an outpatient basis for low risk cardiology patients at Beaumont.

Balloon angioplasty is a mechanical procedure that involves the insertion of a catheter tipped with a balloon that is inflated to compress plaque that is obstructing or blocking heart vessels.

More than 350 outpatient procedures have been performed at Beaumont since an outpatient angioplasty program was launched last year. William W. O'Neill, MD, chief of cardiology at Beaumont, estimates that up to two-thirds of elective balloon angioplasties could be performed on an outpatient basis with no risk to the patient.

"The shorter hospital stay benefits the patient by allowing them to recuperate more comfortably at home," explains Doctor O'Neill. "It does not threaten the safety of the patient and helps the hospital to better optimize its resources for other patients requiring hospitalization."

The average hospital stay for inpatient angioplasty is three to four days versus 10 to 20 hours for an outpatient procedure. Only patients at low risk for complications are considered for outpatient angioplasty. Those who have undergone a previous angioplasty are ideal candidates for an outpatient procedure.

Following the procedure, angioplasty outpatients are monitored in a short-stay Telemetry Observation Unit (TOU) at Beaumont, created specifically for their needs. Before release, patients and their families receive detailed aftercare instructions. Nurses call periodically to check on the condition of the patient at home. There have been no medical complications so far among the hundreds of Beaumont patients treated on an outpatient basis.

The Blues invest $138 million in new computer systems

Blue Cross and Blue Shield of Michigan (BCBSM) President and Chief Executive Officer Richard E. Whitmer announced July 31 that the company will invest an estimated $138 million in an accelerated program of rebuilding it's computer systems to deliver more personalized service to customers, subscribers, and health care providers.

The investment, approved by the Board of Directors, requires an initial capital outlay of $12 million this year to get the project underway.

"We're rewriting our long-term commitment to provide cost-effective, world-class service to the people who purchase our coverage and the medical care providers who serve them," Whitmer declared. "We're also restating a commitment to our employees that we intend to protect jobs by keeping the company on the cutting edge of competition and technology.

"The $138 million investment is needed to sharpen our competitive edge for the 1990s. As technology

Continued on page 10

Continued from page 9

makes products and services more alike, the winners in business will be the companies that provide the utmost in customer satisfaction."

The company also is preparing a major employee retraining program to stress enhanced service, according to Whitmer.

"It's part of a company-wide project to redefine our corporate culture in terms of a new attitude, and to develop a team-building approach to better serve the rapidly changing health care marketplace," he added.

Whitmer said the investment will cover 53 projects over five years and will be structured to cause little or no effect on health care premiums.

"Each step of the comprehensive, planned program will greatly increase the company's ability to manage expanding volumes of information in such areas as enrollment, benefits, claims, and administration. The information that is essential to both quality care and cost control," he said.

Whitmer said the project, called the Information Systems Plan, marks formal recognition that the company's business is shifting from claims processing to information processing.

"While public perception today is linked to how well we process 80 million claims and nearly seven million inquiries annually, tomorrow's measure will be how astutely we gather, classify, assimilate and use information," he stated.

Sinai first in State to use pulsed dye laser

Sinai Hospital, Detroit, continues its tradition of innovation in laser surgery with the recent addition of a Candela SPTL-1, a pulsed dye laser. The laser, the first one of its kind to be used in Michigan, adds to the hospital's clinical and research dimensions in is Laser Surgery and Photobiology Institute.

It means that adults and children, even infants, who have congenital port-wine birthmarks, can now obtain more effective treatment locally. Previously, they were forced to travel as far as Boston for the series of laser treatments that ultimately erases the often disfiguring stains.

Sinai Hospital specialists in dermatology, plastic surgery and gynecology are in the forefront in treating patients with the new laser. In the future it also may be used in oral surgery, ophthalmology, and gastroenterology.

Until now, the continuous wave argon laser was the treatment of choice for removing birthmarks and broken blood vessels.

"The pulsed dye laser has several advantages in treating congenital birthmarks and broken blood vessels," said Barry Auster, MD, a dermatologist in Sinai's Department of Medicine. "The new laser minimizes scarring (which occurs in five percent of cases with the argon laser); it is less painful so that little or no anesthetic is needed, and it preserves normal skin texture."

The new laser also has been first used at Sinai in the investigational treatment of vulvodynia, a painful condition associated with intense vascularity in the vulvar area. "Vulvodynia affects women of all ages and is becoming more common," said Richard Reid, MD, of Sinai's Department of Obstetrics and Gynecology. "The constant pain and intense discomfort causes some women to become completely debilitated."

According to Doctor Reid, topical creams and laser treatments previously used have not been successful in completely removing the abnormal vascular area. It appears that better results are achieved with the pulsed dye laser.

The pulsed dye laser, a 577 mm yellow light, emits a high intensity beam with a very short pulse width. As a result, there is much less heat damage next to the surgical site.

Physicians in the News

William N. Kelley, MD, chairman of the Department of Internal Medicine at the U-M Medical Center, is editor-in-chief of the new "Textbook of Internal Medicine," published by J.B. Lippincott Co. The textbook, created for use in both academic and clinical settings, was a three-year project that involved more than 500 contributors. In addition to Doctor Kelley, two of the other textbook editors are professors of internal medicine at U-M — H. David Humes, MD, and Tadataka Yamada, MD.

Jose Goldman, MD, PhD, is the new president of the board of directors of the American Diabetes Association (ADA)-Michigan Affiliate. Doctor Goldman is an associate professor of internal medicine at the U-M Medical School. He will serve as the ADA-Michigan Affiliate president for a one-year term. He formerly served as vice president and chairman of the Research Peer Review Committee.

Luke Y. Tsai, MD, has been named director of the Division of Child and Adolescent Psychiatry at the U-M Medical Center. Doctor Tsai, an associate professor in the Department of Psychiatry at U-M, will direct a 100-plus member staff that provides evaluations for patients under age 18. He also will serve as director of the fellowship training program in child and adolescent psychiatry.

Raymond Monto, MD, recently retired from Henry Ford Hospital (HFH) in Detroit after 50 years of medical service. Doctor Monto graduated from the University of California and served his internship at HFH. He was inducted into the United States Air Force and served as the Chief of Medicine at a station hospital until 1946. Doctor Monto then returned to HFH. He was the Chief of Hematology for 31 years, staff physician in Oncology for three years, and just recently served as a consultant for *Executive Medicine.*

Bruce M. Carlson, MD, PhD, has been appointed chairman of the U-M Department of Anatomy and Cell Biology. As chairman, Doctor Carlson will guide the teaching and research programs of that department. He has been on the U-M faculty since 1966 where he has served as a professor of anatomy since 1975 and professor of biology since 1979. Doctor Carlson is a co-editor of the *American Journal of Anatomy and Experimental Cell Biology*, and is anatomy editor for the *Encyclopedia Americana.*

Thomas L. Haynes, MD, director of medical services, Glenbeigh of Kent Community Hospital, Grand Rapids, visited four cities in the Soviet Union during May as part of a delegation of addiction medicine specialists from the United States. The delegation met with Soviet narcologists to discuss the treatment of alcoholism and drug addiction in our countries.

New Medico — Ann Arbor facility now licensed for rehab services

New Medico Community Re-Entry Services of Ann Arbor, a part of the nationwide New Medico Head Injury System, has received license by the State of Michigan to provide rehabilitation services for the adolescent head-injured population. The New Medico facility is now licensed to serve both adults, ages 18 years and older, and adolescents from 11 to 17 years old. Previously licensed for 26 adult beds, New Medico's Ann Arbor facility now has 16 adult beds and 10 adolescent beds.

New Medico Community Re-Entry Services of Ann Arbor provides a new treatment alternative for head-injured youth and adults. The facility opened last winter in affiliation with the Department of Physical Medicine and Rehabilitation at the University of Michigan Medical Center. A post-acute head injury rehabilitation center, the residential program works with head-injured individuals to provide skills for independent living and self-sufficiency.

Most rehabilitation activities take place at the facility, located at 3200 Eisenhower Parkway, where participants progress from highly supervised settings to less structured environments. Services also are provided in the community where clients practice the basic elements of independence.

In the Midwest, the New Medico Head Injury System provides a continuum of care through the Ann Arbor facility, the New Medico Rehabilitation Program at Visitors Hospital, an acute care facility in Buchanan, Michigan, and New Medico Community Re-Entry Services of Michigan in Battle Creek. While New Medico's Buchanan facility focuses on acute head injury care, the Battle Creek program is a post-acute rehabilitation center providing skills for independent living and self-sufficiency for recovering head-injured individuals.

The New Medico Head Injury System, with over 35 facilities, is the nation's largest network of head injury treatment facilities. For more information on the New Medico Head Injury System, call 1-800-CARE TBI.

Henry Ford researchers look for ways to predict osteoporosis

Investigators at Henry Ford Hospital are trying to determine whether there are any key physiological traits which make some women more susceptible to osteoporosis than others.

More than 24 million Americans suffer from osteoporosis, a potentially crippling bone disorder that is characterized by an exaggerated loss of bone tissue and an increased susceptibility to fractures.

Backed by a five-year, $1.5 million grant from the National Institutes of Health, researchers in Henry Ford Hospital's Bone and Mineral Division are working to develop an accurate method of identifying individuals who are at greatest risk for developing the disorder so that treatment efforts can be targeted to those women who need it the most, according to Michael Kleerekoper, MD, head of the division and principal investigator for the study.

"We may find that some older women can relax and not worry about bone loss, while others may desperately need treatment to minimize bone loss and help prevent osteoporosis," he said.

The study will monitor bone loss in post-menopausal women who didn't have estrogen replacement therapy (ERT) during menopause. ERT is currently considered the most effective preventive measure for fighting osteoporosis.

"We already know that all women lose bone during menopause and that estrogen replacement therapy can slow the rate of loss and help prevent the development of osteoporosis," said Doctor Kleerekoper. "But we also know that 10 years after menopause most women no longer respond to estrogen as a means of slowing bone loss."

Unfortunately, for a variety of reasons, a significant number of women "miss the boat" on estrogen replacement therapy. Results of this study could eventually help physicians find treatments or therapies that will offer those women a second chance to maintain stronger, healthier bones as they grow older.

Up to 400 randomly selected members of Health Alliance Plan over the age of 60 will be recruited to participate in the study. Each participant's family and medical histories and known risk factors (such as smoking, early menopause, sedentary lifestyle, and excessive consumption of alcohol or caffeine) will be taken into account as researchers try to isolate those factors which have the greatest influence over an individual's likelihood of developing osteoporosis. In addition, each participant will undergo biochemical testing (which involves laboratory analysis of blood and urine samples) and will have their bone mass measured by low-dose X-ray up to six times during the next two years.

Make nominations soon for new AMA awards

Nominations are now being accepted for the American Medical Association's new Dr. Nathan Davis Awards. The awards will recognize elected officials and career government officials who have made notable public service contributions toward improving the quality of health services.

Named in honor of Nathan Davis, MD, AMA founder, the awards will be bestowed upon one individual in each of the following categories: US senator; US representative; presidential appointee serving in the executive branch of government; career public servant in the executive branch; governor; state legislator; mayor or elected county chief executive.

Awards recipients will be selected by a panel of distinguished individuals from the public, private and organizational sectors.

Criteria for the 1989 awards are:

- Outstanding public service accomplishment in 1988 and 1989.
- Is a recognized leader in one of the seven fields.
- Contributed to broaden public awareness of health matters.
- Promoted the art and science of medicine through government service.
- Developed a special project that contributed to the public health of a specific community or selected population.

Nominations must be made soon since the awards, expected to be a major national event, will be presented at a dinner next October in the Nation's Capitol. Submit nominations to: Dr. Nathan Davis Awards, Office of the Secretariat, c/o Suite 870, 1050 Connecticut Avenue NW, Washington, DC 20036.

Direct telephone inquiries to the Awards Secretariat at (202) 785-1391.

WSU undergrads conduct cancer research for credit

An innovative Wayne State University undergraduate laboratory course, now in its 10th year, has proven itself to be a success and a worthy role model for emulation, according to the program's originator and supervisor, Kenneth V. Honn, MD, director of the cancer biology division of the department of radiation oncology at the medical school and adjunct

Continued on page 12

Continued from page 11

professor of chemistry.

"Introduction to Biomedical Research," the formal title of the program, has two main goals," according to Doctor Honn. "First, we want to increase the amount of hands-on laboratory instruction available to our biological science students. Secondly, we hope to interest some of these students in biomedical research by giving them experience in a real research environment, as opposed to a typical lab course."

The program admits about 15 students each year after a vigorous screening process. Successful applicants have come from a variety of majors, including biology, chemistry, physics, and psychology. "We ask for a heavy commitment from our students," says Doctor Honn. "The 2-credit course requires 15 hours a week in the lab for 52 weeks.

Each new student is introduced to the Cancer Biology Lab, located in the Chemistry Building on the main campus, with a training program in basic laboratory skills. After this orientation period, the student is assigned to be a member of an existing research team, headed by a professor, a postdoctoral student, or in some cases a senior level predoctoral student. Each research team may consist of from two to seven individuals in addition to the student.

The newcomer is closely supervised and briefed by the group leader about the goals of research being conducted. The research subjects include such areas as radiation effects on cells, overcoming cancer cell resistance to chemotherapy, and detection of highly metastatic cells. Eventually, the new students are given real research tasks and responsibilities, and many students have designed and conducted projects of their own within the larger framework of the group.

The opportunity for hands on research and the minimum one-year duration of the program are the significant differences between Doctor Honn's program and other laboratory and directed studies classes.

Seaway Hospital now provides hospice care downriver

Seaway Hospital in Trenton now provides short-term inpatient care to Hospice of Southeastern Michigan (HSEM) patients, making Seaway Hospital part of the only full service program in the Downriver area. Seaway joins two other Detroit hospitals, Mount Carmel Mercy and Saratoga, that have the distinction of being inpatient HSEM facilities.

Seaway Hospital provides pain management and symptom control for up to four patients admitted into the HSEM program whose condition can no longer be managed in the home. Usually, a hospice patient will stay in the hospital about three to five days. Those patients admitted to Seaway will typically be suffering from extreme pain, respiratory distress, seizures, or other symptoms. Patients are returned home once their condition is stable.

Several Seaway nurses trained in hospice care and two Seaway physicians help coordinate treatment for these patients, with the support of HSEM staff. Hospice patients can have their own physician or HSEM physician manage their care.

Hospice of Southeastern Michigan is a nonprofit agency that provides hospice care and counseling to terminally ill persons and their families in Wayne, Oakland, and Macomb counties. Founded in 1980 with help from several hospitals, including Peoples Community Hospital Authority (the predecessor to United Care), HSEM has helped more than 3,000 patients live with a sense of personal worth and dignity until they die.

For more information, call Hospice of Southeastern Michigan at (313) 559-9209 or Seaway Hospital at (313) 671-3800.

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M.D.

Cover Story

Risk Prevention

Now, more than ever, it is assuming a significant role in the activity of organized medicine

By Robert E. Paxton, MD

Risk management — it's a basic concept that always has been a part of continuing medical education. Now more than ever, though, risk management is assuming a significant role in the activity of organized medicine. As I see it, there are two driving forces contributing to this conclusion.

First of all, it is politically expedient for MSMS to demonstrate a keen interest in risk management. Legislators have to be convinced that we are addressing this aspect of the professional liability problem before they will consider any further tort reform or tort alternatives.

Secondly, and perhaps more important, this concept represents an ever enlarging scope of activity for MSMS that will include practice management services, establishment of practice parameters through the specialty societies and dissemination of data to reduce risks where possible.

This has stimulated the MSMS Board of Directors to establish a Section on Risk Prevention within the Department of Finance, Member Services and Operations, effective December 1. The Section will utilize services already available through the insurance companies as well as establish innovative ideas of our own.

The point I want to make is that risk prevention is not an activity limited to instruction on how to protect oneself in case litigation occurs. Rather, it is a comprehensive program that ultimately leads to maintaining high quality medical care for our patients — the bottom line for all MSMS endeavors.

There always is concern that standards of care are a two-edged sword, in some cases increasing the risk of liability. Also, traditionally, the bureaucratic establishment of standards gets bogged down in mediocracy. All of which makes MSMS involvement mandatory to insure physician input into the process.

Risk management is a timely subject. It is important. It is here to stay. Consequently, this month's cover story is dedicated to risk management, or perhaps more appropriately, risk prevention. I encourage you to read on. ■

Doctor Paxton is MSMS president and chairman of the MSMS Task Force on Professional Liability.

Risk Management Key to Reducing Liability and Promoting Quality, says MPMLC

By Thomas R. Berglund, MD

Who would have thought 10 years ago that the term "risk management" would be as commonplace in medical journals as it is in insurance newsletters?

The reason is obvious. The cost of liability insurance is a front-burner issue. One of the few ways for physicians to lower their liability costs in the short-run is through risk management.

Hopefully, physicians also keep in mind the long-term objectives: to reduce the number of injuries to patients and to enhance quality of care. Lowered liability costs will be the secondary effect of achieving these objectives.

These concerns and issues were a priority at Michigan Physicians Mutual Liability Company (MPMLC) long before risk management was a common topic of discussion among physicians and medical administrators. They remain a priority because we believe risk management works. Risk management offers physicians an opportunity to identify and minimize liability risks, and to analyze statistics for targeting and addressing needs.

MPMLC activities

The following activities reflect MPMLC's commitment to risk management.

The Merit Rating Program. For participating in risk management activities, physicians can lower their liability insurance premiums with merit rating credits. At MPMLC, physicians have a choice of several approved risk management activities:

- Office risk analysis and education program;
- Follow-up office risk analysis;
- Risk management seminars;
- Closed-claims reviews;
- Risk management correspondence courses; and
- Use of approved patient information systems.

Participation in a combination of these programs will reduce insurance premiums by four, six, or eight percent, depending on which programs are chosen. The maximum premium credit is given to those who choose an office risk analysis and two of the other programs, or any four programs excluding the office risk analysis. Two types of specialists — obstetrician/gynecologists and anesthesiologists — may earn an additional five percent premium credit by complying with guidelines adopted by their medical specialty societies. Combined with risk management activities, adherence to these guidelines can result in premium savings up to 13 percent. Merit rating programs are the result of 1986 tort reform legislation.

Risk Management Seminars: A Joint Effort. As risk management programs increase in scope, positive impacts will be undeniable. MPMLC and the Michigan State Medical Society share strong interests. MPMLC teamed up with the Michigan State Medical Society (MSMS) to offer a series of 15 risk management seminars. The purpose: to promote risk management principles and to help physicians focus their efforts in problem areas. The seminars offer risk management techniques such as improving patient communication skills, improving medical record documentation, and preparing for a legal defense. The 10 seminars held to date have attracted 650 physicians, who have generally given the programs high marks. Next year's conferences will offer more variety, exploring such topics such as mediation and legal proceedings in malpractice cases. Remaining seminars will be held Sept. 13 in Troy at the Somerset Inn, Sept. 21 in Escanaba at the House of Ludington, Sept. 27 in Ann Arbor at the Holiday Inn, Oct. 12 in Grand Rapids at the Amway Grand Plaza, and Oct. 25 in East Lansing at the Kellogg Center.

Data extremely valuable

One of the most valuable aspects of risk management is analyzing claims to target problem areas and reduce future risk. For example, MPMLC's top 10 medical specialties facing the greatest frequency of claims are obstetrics/gynecology, general surgery, general practice (with minor surgery), internal medicine, general practice, orthopedic surgery, diagnostic radiology, family practice, internal medicine (with minor surgery) and anesthesiology.

The order changes when calculated by total indemnity and expense. However, obstetrics/gynecology and general surgery rank at the top in number of claims and total costs.

Statistics pinpoint general patterns across all specialties and for patterns within specialties. For example, **Figure 1** shows the most common reasons for claims, based on MPMLC claims history. **Figure 2** shows the top three reasons for claims among the 10 most-sued specialties. Patterns within specialties are highlighted in closed-claims reviews, where case-specific issues or problems are comprehensively discussed.

A look at the future

In states with unfavorable liability climates, the demand for risk management programs is high. In Michigan, which has notoriously high liability costs, there is accelerating demand for risk management programs. In addition, physicians want a more sophisticated, more focused approach to programs because many now are familiar with basic risk management.

The Stratton-Cheeseman Management Company (SCMC), which manages MPMLC, therefore is developing more programs for medical specialists. Those include closed-claims reviews and specialty seminars, which address clinical issues rather than generic office procedural issues. In addition, the trend toward using specialty guidelines will accelerate.

Risk management begins with the physician, but also should involve other health professionals and support staff.

A broader range of risk management programs is in the works at SCMC. SCMC is planning to offer new programs for physicians in resident training programs, for ancillary staff, and for those working in home health and ambulatory settings.

These new SCMC programs will move the medical community closer to its goal: to research, develop, and refine programs to meet health care needs, while enhancing quality and reducing patient injury. ■

Doctor Berglund is president of MPMLC and is secretary of MSMS.

Figure 1. Based on MPMLC historical data, 1976-1989.

TOP 10 MALOCCURRENCES
INDEMNITY + EXPENSES

MALOCCURRENCES	TOTAL
ERROR IN DIAGNOSIS	$79,281,274
PROCEDURE IMPROPERLY PERFORMED	$61,383,606
NO MEDICAL MISADVENTURE*	$14,360,066
PROCEDURE NOT PERFORMED	$14,205,516
DELAY IN PERFORMING PROCEDURE	$12,473,760
FAILURE TO MONITOR PATIENT	$12,143,092
MEDICATION ERRORS	$12,006,709
UNNECESSARY PROCEDURE	$9,465,987
MORE APPROPRIATE ALTERNATIVE	$9,228,882
FAILURE TO RECOGNIZE COMPLICATION	$7,418,172

*Problems unrelated to medical care.

Figure 2. Based on MPMLC historical data, 1976-1989.

TOP 3 MALOCCURRENCES
FOR MOST-SUED SPECIALTIES

SPECIALTIES	MALOCCURRENCES
OBSTETRICS/GYNECOLOGY — SURGERY	Procedure Improperly Performed Error in Diagnosis Procedure Not Performed
GENERAL SURGERY	Procedure Improperly Performed No Medical Misadventure* Error in Diagnosis
GENERAL PRACTICE — MINOR SURGERY	Error in Diagnosis No Medical Misadventure Procedure Improperly Performed
INTERNAL MEDICINE	No Medical Misadventure Error in Diagnosis Procedure Improperly Performed
GENERAL PRACTICE	Error in Diagnosis No Medical Misadventure Medication Errors
ORTHOPEDIC SURGERY	Procedure Improperly Performed No Medical Misadventure Error in Diagnosis
RADIOLOGY — DIAGNOSTIC	Error in Diagnosis No Medical Misadventure Procedure Improperly Performed
FAMILY PRACTICE	No Medical Misadventure Error in Diagnosis Procedure Improperly Performed
INTERNAL MEDICINE — MINOR SURGERY	No Medical Misadventure Error in Diagnosis Procedure Improperly Performed
ANESTHESIOLOGY	No Medical Misadventure Procedure Improperly Performed Legitimate Risk of Procedure

*Problems unrelated to medical care.

Parameters of Care Key to Solving the Liability Problem,

Says James Todd, MD

Editor's note: In a recent speech given before the Physicians Insurers Association of America, AMA senior deputy executive vice president James Todd, MD, discussed the important role risk prevention and the establishment of practice parameters play in the professional liability battle. What follows are excerpts of his presentation.

We in the medical profession have a responsibility to protect our colleagues from the ravages of professional liability. That, in turn, becomes a service to our patients and to society at large. But we know that the ravages of professional liability have not lessened anywhere near to the degree we would like to see them. We know, and we should tell the public, that a physician, once sued, is never the same again. That loss of confidence, that direct insult to their professionalism and their abilities is never regained.

Statistics show that the reduction of services in parts of this country require patients to travel miles and miles to get treatment that ought to be readily available in their local area. We know about the loss of talent of young people who decide they're not going to go into the medical profession, not only because of government regulation and harassment, but also because they don't want to face the stark reality that some one of their patients — that they're doing their best to help — may turn around and sue them.

It is really a sad commentary when in *Medical Economics*, not too long ago, a poll was done of physicians who were asked what they were doing in response to the professional liability problem. Twenty-seven percent of them said they were going to retire early.

By working together, collectively and cooperatively, we have capitalized on our strengths, we have made some remarkable progress. I've said it before, and it has not been very popular that whatever it is we think we're about, in reality what we are talking about is behavior modification — modification of the behavior of the public...attorneys...some of the insurers, and most assuredly, physicians. And what we're really about in that modification of behavior is better patient care, better patient satisfaction, and eventually, the reduction of costs of professional liability, both in terms of money and in personnel in the profession.

Risk prevention

I remain convinced that we in the profession, both physicians and insurers, working together, by ourselves, within our own organizations, can probably make the greatest impact of all. Because, afterall, it is the doctor/patient encounter which is at the root of every single suit that ever gets filed. No suits are filed if a patient hasn't been to a physician. Attorneys tell me again and again that the majority of the people who come to see them are angry, not necessarily injured, but angry. And sometimes it is the plaintiff attorney that has to find the injury for the patient so that they can file a suit for something other than anger. If this is so, than we ought to be talking about risk prevention, not risk management. Risk management is what you insurance folks do after the event has occurred. We physicians and you and your companies need to be talking about risk prevention. I believe this increasingly needs to be the cornerstone of our activities.

Parameters of care

The reluctance, indeed the resistance, to develop anything that sounds like standards, guidelines, or what we prefer to call at the AMA parameters of health care, worries me. And we chose the word parameters very carefully, because to us parameters means a range of acceptable behavior in the management and treatment of patients.

Nobody really seems to want to get involved in establishing parameters. And the resistance is about equally distributed between the medical profession, the insurance companies and the specialty societies. And yet, look at the anesthesiologists. They drew up probably one of the tightest series of guidelines any specialty has developed. They have not suffered. Their frequency is down, their severity is moving down, but most importantly, their rates are moving down.

Some companies are selectively underwriting and "ridering out" certain things that they won't cover if physicians do them. That to me, is sort of parameters in reverse. But let's be candid about it. Medical technology and science have advanced so far today that no physicians, regardless of how narrow their specialty, can be up to date on all things at all times regarding their patients.

We need to produce the sort of information that will help physicians maintain acceptable ranges of practice. And just as risk prevention is coming of age, based on good data, so it seems to me it becomes equally important to define acceptable ranges of medical treatment that we can all agree are based on medical scientific information, not the whims of professional experts and uninformed juries. This information interpreted, refined and defined by physicians will be accepted by physicians. And if done properly, using up-to-date information, packaged to reflect local resources, designed to improve patient care by aiding the physician decision making process, and specialty specific as much as possible, I believe that these parameters will be of comfort to physicians in trying to decide how to treat their patients. It also will be of benefit to your companies as you try to decide whether to defend a suit.

I have no patience with physicians or insurance companies that say that this would be a bonanza to the plaintiffs bar, that it would give them a handbook on how to sue physicians. They're not dumb. Some of those plaintiffs attorneys out there know as much about medicine as we do. We're not going to tell them anything they don't already know. But we're going to put it between two covers in offensive parameters and say you know this is what the profession has agreed upon, and if a physician practices within those parameters, Mr. attorney, you really don't have a case. Put most simply, what is right is right and we ought to be doing it.

Once again, in my judgment, the ultimate goal of all of our activities is the improvement in the quality of care physicians provide. And we should form the definition of what that quality care is, not the courts. Indeed, we should be willing to embrace it because it is good for us, it is good for patients, it's going to be good for your insurance companies. And clear deviations resulting in injury should be promptly compensated. Adherence to good medical practice should be strictly defended, because so often today we deal in the gray zone where nobody really knows what the truth is — and that's how professional witnesses make their living.

Parameters of care modified by local resources and the prudent physician can provide a degree of predictability and security that we do not now enjoy. To be held clearly accountable to good medical standards is in our best interest. And those who deviate should pay the price, not only in monetary terms but in terms of protective underwriting, re-education, rehabilitation, or in the extreme, elimination from the profession if they will not cooperate.

Closing remarks

There is no ultimate solution to professional liability. It's never going to go away. Doctors aren't perfect, they're going to make mistakes. There are going to be those who are careless, callous and uncaring. Attorneys are always going to try to make a living at whatever method they can. And our society is increasingly demanding a risk-free environment. Put that together along with the courts, that seem to me to be more concerned with the transfer of wealth than justice, the problem is not going to go away.

Our task is to reduce these continuing factors to an absolute minimum and restore an atmosphere that will allow physicians and patients to work together, not fearing that one will be harmed by the other, and that we will get back to a doctor-patient relationship that is predicated upon trust, faith and good science. How well we succeed in all of this depends upon the commitment of each and everyone of us, regardless of what we do in this world. A renewed commitment of each one of us to the principles of high quality care. Each one of us has a responsibility to maintain excellence in whatever we do. Based on the accomplishments of the past and the potential of the future, working together, and I really mean working together, I am convinced that we will not only endure, we might even prevail.

Physicians are in the Best Position to Determine Risk Management Guidelines, PICOM says

By Issac J. Powell, MD

A recent *Time* magazine cover was illustrated with a caricature of the Aesculapius – the symbol of the medical profession. The usually benign serpent was coiled, with fangs full of venom, and ready to strike. This was a dramatic visual metaphor for the article which focused on the growing frustrations felt by patients and doctors alike.

The erosion of the relationship between physicians and the public has been due to a number of factors. Increasingly, these factors fall outside the medical profession. The federal government, plaintiff attorneys, and a growing body of regulations have defined every aspect of practice from billing to business relationships to standards of care. These political and legal forces generally regard medicine as an economic commodity requiring cost containment on the one hand and providing lucrative opportunities for attorneys on the other.

A look at PICOM's program

At the Physicians Insurance Company of Michigan (PICOM), insurance and risk management programs have been created with the belief that physicians are in the best position to decide what practice standards and risk management guidelines they must follow. To that end, we have worked closely with specialty societies to begin the process of developing protocols for care. After a careful review of closed claims, the Michigan Academy of Family Physicians (MAFP) and PICOM staff identified situations which put a family physician at high risk for being sued. Closed claim and other research provided the basis for educational programs and office audits. Clinical risk management guidelines then were developed and presented in a loose-leaf manual.

This spring PICOM board member, Doctor William Woodhams, presented the guidelines on a videotape which has seen statewide distribution. Additional programs are being developed in cooperation with the Michigan Society of Anesthesiologists and other specialty groups. These clinical risk management guidelines will move us closer to defining accepted protocols or standards of care.

Workable standards

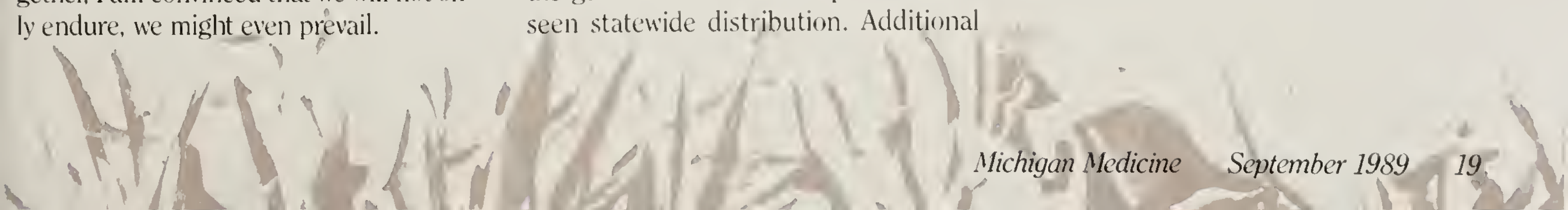
In order for standards to be workable they must be realistic, measurable, and current. Guidelines need to be revised and updated periodically to account for technical advances and changes in the liability environment.

In a recent article I authored for the American Urological Association, I outlined a number of benefits to be gained by establishing standards. Two of these benefits address issues of patient relations and liability:

1) *Standards will help reduce the confusion regarding malpractice and maloccurence. In defining standards, courts often have been unable to distinguish between the two.* Standards must distinquish carefully between negligent care and acceptable, predictable complications. These definitions must include acceptable variations of care, reasonable versus unreasonable judgement, indications and non-indications.

The explosion in litigation has resulted in a chilling effect on medical innovation and creativity. At the same time, deviation from established minimum standards in high risk areas may be unacceptable. An ongoing study of closed claims by the American Society of Anesthesiologists demonstrated that deviation from standards of care resulted in both greater likelihood and amount of settlement payment (*New England Journal of Medicine*, 3/17/89, Vol. 261, No. 11, P. 1603).

2) If communicated properly, standards can improve the physician/patient relationship. *Standards should be communi-*



cated directly to patients. For too long outside forces have made doctors adversaries with their patients. Standards defined by the medical profession could contribute to the restoration of the physician as healer and patient advocate. They would allow patients to participate in their care, thereby increasing the opportunity for a strengthened bond between physician and patient.

As we move toward the goal of established protocol, a number of activities will be offered to physicians under the general heading of "risk management." At PICOM we continually analyze program content and credentials associated with these programs and publish lists of endorsed organizations. This includes educational seminars offered jointly by MSMS. To offer further incentive to physicians, we provide flexible premium discounts for participation in any endorsed program.

Physician participation vital

As physicians we must continue to participate in the ongoing development of risk management activities with the goal of establishing standards in areas that present high risk. Through this endeavor we will take the definitions of standard care from the courts and regulators, and return them to the doctors and patients they serve. ■

Issac J. Powell, MD, is a board member of PICOM and serves as chairman of the PICOM Risk Management Committee. He is outgoing president, Michigan Urological Society.

Cover Story

Anesthesiologists: A Success Story

By Chad Munger

Risk management guidelines are making anesthesiology a healthier profession. In a profession dominated by rising insurance rates and almost paralyzing liability costs, this medical specialty has turned self-evaluation into self-preservation.

Anesthesiology, a specialty which less than a decade ago rivaled obstetrics and gynecology as one of medicine's most legally perilous, now is one of its more unassailable. Credit for this almost complete reversal goes not to any new technology, but to the specialty's willingness to agree upon a set of self-imposed guidelines of care. This rare attempt at self-monitoring through a set of written guidelines, which many physicians fear border on professional "standards," has provided a socially acceptable basis on which to judge the acceptability of the practice of anesthesiology. These guidelines have helped make peer review better respected and have had a tangible impact on the cost of liability insurance.

Anesthesiology's move toward self-imposed guidelines to care began with the Harvard Medical School in 1984. At this time the Harvard Medical School's Department of Anesthesiology moved to overcome the nationwide trend of increased anesthesia-related incidents and malpractice suits. A committee of medical school faculty was established to suggest guidelines which would reduce the number of anesthesia-related incidents and malpractice suits. A committee of medical school faculty was established to suggest guidelines which would reduce the number of anesthesia-related incidents at the school. These suggestions, it was hoped, not only would improve patient care, but also would make anesthesiologists more aware of their practices, would "standardize" acceptable practices within the hospital, and possibly would lead to lower insurance premiums. These goals have met with a good deal of success.

In 1986 the American Society of Anesthesiologists (ASA) adopted a modified version of the Harvard guidelines and made anesthesiology the first medical specialty to adopt written guidelines of care. State branches of the Society soon followed suit.

Guidelines key to lower rates

For doctors choosing to follow the guidelines established by the ASA and their state societies the result often has been lower insurance rates. Michigan is a classic example. For Michigan physicians insured by the Michigan Physicians Mutual Liability Company (MPMLC), the following guidelines of care have a direct impact on the insurance premiums they pay. Physicians agree to follow guidelines concerning:

- Physical presence
- Monitoring
- Oxygenation
- Ventilation
- Circulation
- Body Temperature
- Anesthesia Care Supervision
- Equipment
- Obstetrical Anesthesia
- Documentation

In Michigan, anesthesiology was an insurance risk group "eight" before 1986. Today it is a more acceptable "four." Physicians adhering just to specialty guidelines receive a five percent premium credit from MPMLC. In addition, MPMLC gives premium credits at four, six, and eight percent to physicians adhering to various other risk management guidelines, which are not strictly specialty oriented. Seventy-two Michigan physicians take advantage of the MPMLC's premium credit for specialty risk management guidelines and some 160 physicians receive one of company's four credits.

Simplicity a key factor

The success of the guidelines, at least in Michigan, may be attributed to their simplicity. Gary Maynard, MD, a Kalamazoo-based anesthesiologist points out, "If you really look at what anesthesia did, in terms of guidelines, it is really very basic to begin with. There is nowhere that anesthesiologists are told how to administer anesthesia other than how to monitor it."

The ASA and other societies of anesthesiologists have managed to circumvent many physicians' fear of creating an absolute set of practices which will make malpractice an even greater possibility than before guidelines were established.

Doctor Maynard comments: "The concern people have is that if guidelines are

established, and I as a physician vary from those standards, am I committing malpractice? People will argue that with guidelines in place there is not enough latitude for people to use their own judgment and do their own thing."

The other side of this argument is that if anesthesiologists do not set their own standards someone else will do it for them. It seems there is little question that every anesthesiologist involved in peer review of malpractice suits would be more comfortable making decisions based on his/her own set of standards.

The medical and financial success of anesthesiology's guidelines of care have not, as yet, found their way to other specialties. This may be because "the type of guidelines anesthesia has developed do not necessarily lend themselves to other specialties," says Doctor Maynard.

Nonetheless, the success anesthesiology has had using its own guidelines to reduce malpractice insurance premiums is a powerful invitation for other seemingly less well-suited specialties to follow suit. Obstetrics/Gynecology, one of today's most vulnerable specialties, is taking a serious look at professional guidelines similar to anesthesia.

The initiatives taken by the ASA and many individual anesthesiologists have proven that risk management is a viable solution to skyrocketing malpractice insurance rates. ■

Chad Munger is an East Lansing-based freelance writer.

Cover Story

MSMS to Establish Section on Risk Prevention

By Betty J. McNerney, Managing Editor

The MSMS Board of Directors recently approved a recommendation to establish a Section on Risk Prevention. Effective December 1, the Section will operate under the direction of the MSMS Department of Finance, Member Services and Operations.

The Section will be staffed full-time by a person who has a background in medical liability insurance loss prevention and/or hospital risk management. Staff responsibilities will include:

■ Advise MSMS members on available risk prevention programs including seminars and office audits.

■ Work with MPMLC and PICOM to develop joint risk management programs.

■ Work with MPMLC and PICOM to identify specialty-specific, high-risk diagnoses and procedures.

■ Assist Michigan chapters of national specialty societies to develop parameters of medical care.

■ Facilitate the AMA/National Specialty Society integrated risk prevention educational program in Michigan. The program will have three parts:

Part 1 – a confidential self-assessment tool to be completed by each physician to determine his/her potential malpractice risks.

Part 2 – a self-study course incorporating non-clinical practice standards and videotaped vignettes.

Part 3 – a follow-up in office survey to measure Parts 1 and 2 and to address recurrent practice difficulties.

■ Coordinate risk prevention programs with the Michigan Hospital Association and the Michigan Hospital Association Mutual Insurance Company.

■ Work with the MSMS Hospital Medical Staff Section and the Michigan Society of Hospital Risk Managers to develop joint hospital/medical staff risk prevention programs.

Other activities

In addition to developing this new Section, MSMS has joined the Michigan Physicians Mutual Liability Company in sponsoring a series of risk management seminars. As of this writing, 650 physicians have attended the seminars, which began in March. Evaluations of the seminars have been very positive. The Physicians Insurance Company of Michigan (PICOM) has approved the seminars for its merit rating program, beginning with the April 19 program in Grand Rapids.

Seminar locations have included Lansing, Kalamazoo, Grand Rapids, Port Huron, Traverse City, Alpena, Marquette, Bay City, Detroit and Dearborn. Dates and locations of the remaining seminars are as follows:

September 13 – Troy – Somerset Inn
September 27 – Ann Arbor – Holiday Inn, Jackson Rd.
October 12 – Grand Rapids – Amway Grand Plaza
October 25 – East Lansing – Kellogg Center

In other news, the MSMS Board of Directors has committed staff resources to assist Michigan specialty societies, represented in the House of Delegates, in developing risk prevention programs including parameters of medical care. The parameters of medical care are to guide physicians in the diagnosis and treatment of specific diseases or conditions. To begin this process, MSMS staff has developed a data bank on insurance company and medical society risk prevention programs throughout the country.

AMA Senior Deputy Executive Vice President James Todd, MD, addressed the MSMS Committee of Specialty Society Presidents at MSMS headquarters in May. Also in May, Doctor Todd addressed the Physicians Insurers Association of America in Boston. He explained to both groups the urgency of developing specialty specific practice parameters so that physicians can't be held liable for untoward results if they follow the parameters. The AMA believes the benefits of trying to formulate effective practice parameters outweigh the risks and has joined with the Rand Corporation in a project aimed at developing practice parameters. Highlights of Doctor Todd's presentation to the Physicians Insurers Association of America appear on page 18. ■

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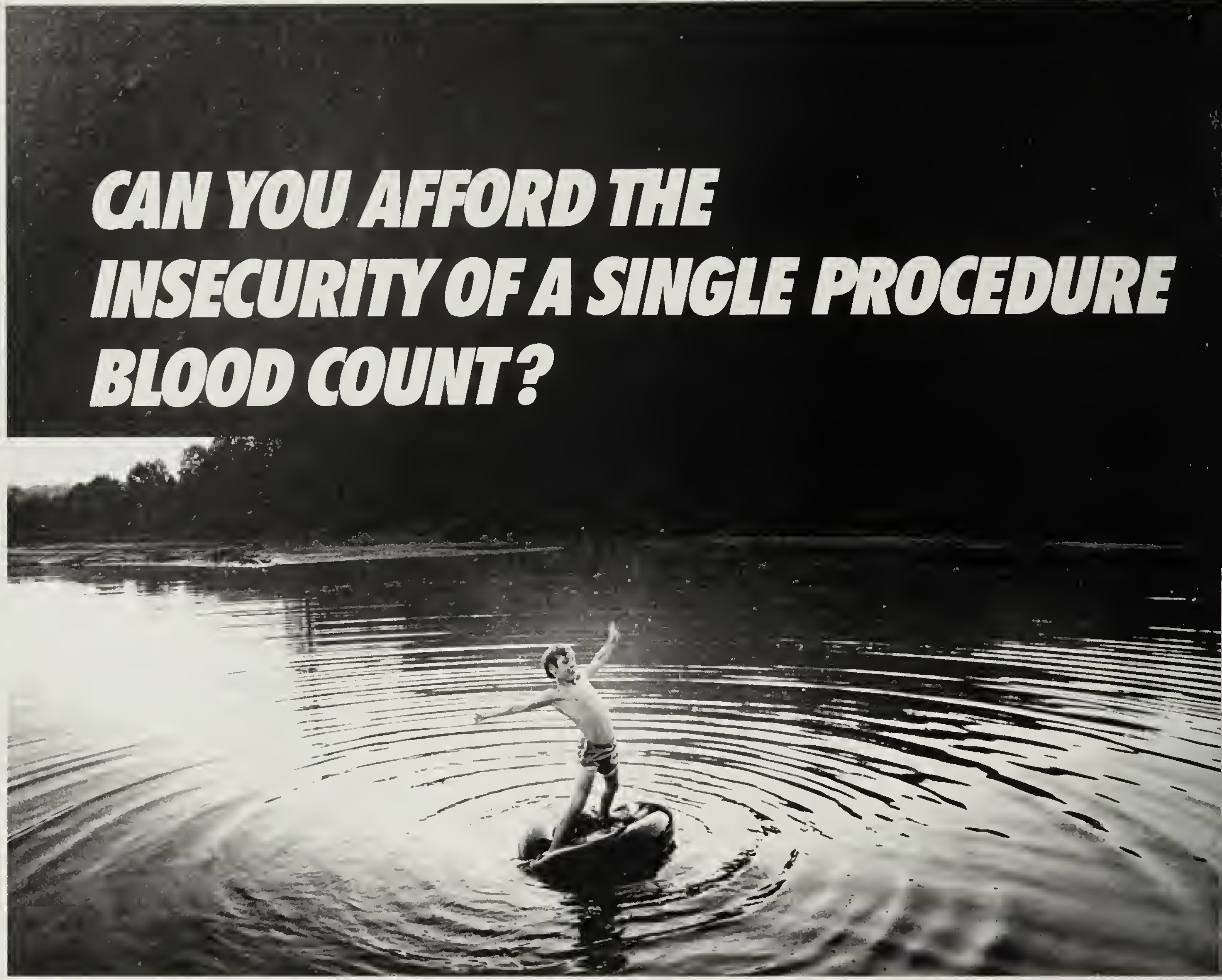

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ROSALYN P. STERLING-SCOTT, M.D.

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Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

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RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
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The Blues Develop New Program Aimed at Utilization Review

By Susan H. Adelman, MD

Of Michigan's nearly 20,000 medical doctors, osteopathic physicians and surgeons, podiatrists and chiropractors, fewer than 2,000 demonstrate "practice variations," according to Blue Cross and Blue Shield of Michigan (BCBSM) data. "This is a tribute to the vast majority of Michigan physicians whose practices are within acceptable peer norms," says Larry Sell, MD, BCBSM senior vice president and medical director.

To address identified practice variations, BCBSM has developed the Physician Retrospective Profiling (PRP) program with input from an advisory committee of prominent Michigan physicians. The PRP program is scheduled for implementation October 1.

"While BCBSM always has profiled physicians, the PRP program is aimed at a much larger audience with particular emphasis on education and graduated intervention strategies," says Doctor Sell.

By advising physicians of their practice variation and monitoring future utilization patterns, PRP will attempt to encourage physicians to adopt practices that are consistent with the cost-effective delivery of appropriate health care services. "But the emphasis will definitely be on education," says program designers. "We feel certain that if physicians are practicing outside the norm of their community, they will certainly want to know that and identify the contributing factors. In many cases, there may be legitimate reasons."

Regardless of the practice variation pattern identified, physicians will be given an opportunity to submit rationale in support of their variance.

In defining practice variation and developing physician profiles, BCBSM utilizes the physicians total number of ranked variant procedures, total BCBSM payment, average services per patient and average payment per patient. These utilization statistics are then compared to market area and state peer group norms to define the degree of practice variation. "This mechanism provides a reliable and equitable method of measuring BCBSM utilization, permits identification of significant practice variations (two standard deviations from the norm) and is a consistent indicator of provider comparisons," says Doctor Sell.

The physicians' degree of practice variation determines the intervention level (one through four) at which they enter the PRP program. The PRP program's intervention strategy is aimed at influencing provider utilization patterns through the application of a series of graduated interventions. The object is to move from minimal intervention (levels one and two) that seeks first to modify questionable utilization patterns through education to direct intervention to alter unacceptable patterns (levels three, four and five) and, if that fails, to eliminate non-compliant providers from the system.

For a full description of each intervention level, see the accompanying article.

Any inquiries about the PRP program should be directed to Michael J. Kesler, manager, Utilization Review Development and Methodology, Blue Cross and Blue Shield of Michigan, 600 Lafayette East, Detroit, MI 48226. ■

Doctor Adelman is MSMS president-elect and is chairman of the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan.

Six Intervention Levels

The primary goal of the intervention strategy is to educate and correct; therefore, the majority of providers will initially encounter intervention levels one or two. In any event, physicians at intervention levels one through four will receive their PRP profile and be given 30 days to submit information/rationale to explain their variance. If the rationale adequately explains their variance, they may be removed from the intervention file and remonitored in the next cycle; be placed at a lower intervention level; or undergo monthly/quarterly monitoring as appropriate. The intervention levels are as follows:

Level one

Physicians in this category receive an educational letter that includes the physician's profile and general PRP program information. This communication will advise providers that BCBSM is prepared to provide assistance and review any rationale/documentation which they feel supports their practice variation. They further are advised that they will be placed on annual monitor and the results of that review will determine their PRP program status.

Level two

Physicians in this category receive an educational letter that includes the physician's profile and general PRP program information. They are further advised that a remonitor to include the two quarters following receipt of notification will occur to determine whether they will be placed on annual remonitor or will proceed to the next intervention level.

Level three

Physicians in this category receive a notification report that includes the results of the two-quarter remonitor or an educational letter that includes the physician's profile and general PRP program information. They are further advised that a remonitor to include the quarter following receipt of notification will occur to determine whether they will be placed on annual remonitor or will proceed to intervention level four.

Physicians in category are expected to demonstrate a designated percentage improvement in their variant procedures and/or groups of procedures during the remonitor. Physicians who attain the designated percentage improvement will

Continued on page 28

Continued from previous page

be removed from the intervention file and reevaluated in the next cycle. Failure to demonstrate significant improvement will result in their proceeding to intervention level four.

Level four

Physicians in this category receive a notification report that includes the results of the quarter evaluation conducted under level three or an educational letter that includes the physician's profile and general PRP program information. They are further advised that they are required to submit a Corrective Action Plan (CAP) and will undergo a remonitor to include the quarter following receipt of notification.

A designated percentage improvement should be shown in the remonitor. Failure to effect the corrective action may result in the initiation of further sanctions (i.e., prepayment utilization review and/or monetary recovery).

Physicians who attain the required percentage improvement will be removed from the intervention file and reevaluated in the next cycle. Physicians who fail to demonstrate significant improvement will be placed in intervention level five.

Level five

Physicians in this category receive a notification report that includes the results of the quarterly remonitor conducted under level four. At that time, they will also undergo an audit to determine whether Prepayment Utilization Review (PPUR) is indicated. Physicians placed on PPUR will have a reasonable time to correct their practice variation or be subject to intervention level six.

Level six

Physicians placed in intervention level six will be departicipated and all future claims are subjected to PPUR with payment directed to the subscriber.

In all situations involving implementation of intervention levels, BCBSM will adhere to the following basic principles:

1) Integrity, accuracy, and precision of the methods and data used to evaluate provider practice patterns.

2) Confidentiality of provider records will be maintained.

3) Providers confirmed as significantly variant will be given a reasonable period of time and assistance to effect improvement.

4) Fair and consistent process will be followed when imposing provider sanctions. ■

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Health Education Foundation is Taking New Directions

By Peter Marabell

Doctor Paxton

"You want me to be blunt? All right, I will. Too many of our members don't know anything about the Health Education Foundation," said Foundation President Robert E. Paxton, MD, in a recent interview. "And many of those who do know about HEF can't really explain what we do. We've got to change that."

"The purposes of the Foundation are the purposes of the Medical Society itself," explained Doctor Paxton, who also serves as MSMS president. "Don't forget that from the very beginning, the Medical Society has supported health education."

The physicians who created MSMS, according to the MSMS Constitution, wanted to ensure that "human welfare (would) be enhanced." They sought to "organize ...societies...to develop and administer programs designed to improve public understanding (and) to stimulate the advancement of the science and art of medicine."

Early focus on academics

In the early days, the Foundation focused its attention on the academic community. It was thought that financial aid for students in medical school would be the most appropriate way to "support health education." Although helping students ease the financial burden of medical school was a laudable goal, there were those who believed that the word "education" ought to be more broadly defined.

As a result, the Foundation entered what Doctor Paxton calls a transition period. "We began to look for other ways to help," he said. "We wanted to reach out and educate people who weren't in medical school." Slowly, HEF began to shift its focus from financial aid to funding independent projects.

Programs and projects seeking support from the Foundation must be non-profit and tax-exempt, of course, and they must be without governmental, religious, or political affiliation. They also must be nondiscriminatory, and HEF is quite proud that all funded projects originate and operate in the state of Michigan.

The Foundation supports programs of research and demonstration in a variety of areas including ethics and bioethics. Because of the limited grant money available, HEF prefers to support short-term and start-up projects rather than to make long-term commitments. A major focus today is on wellness and on healthy lifestyles. It is not enough to encourage research in the diagnosis and treatment of disease. The Foundation also funds programs that improve the quality of life for the people of Michigan.

"We've all heard the term, 'grass roots,'" said Doctor Paxton. "Well, that's where HEF is headed. We are looking at what people want, what problems need to be solved." In fact, HEF uses focus group research in local communities to learn about such health issues as infant mortality. "The grass roots can be anywhere," Doctor Paxton continued, "in the city or in small towns, anywhere people's health care needs aren't being met."

New areas of support

One of the first grants that broke the financial aid mold went to Oakland University in Rochester for a study of health/fitness programs developed by businesses for their employees. Clearly HEF was moving to widen its support. "It was a solid attempt," Doctor Paxton said, "but we needed to do more than give money to worthwhile organizations. We wanted to reach those people who might not otherwise be part of a large, recognized group."

Today, the Foundation is doing just that. It's reaching people who might never see the inside of a medical school. Recently, for example, the Foundation funded the Adolescent Substance Abuse Prevention Program of the Genesee Intermediate School District in Flint.

"There are folks all around Michigan who fall through the cracks," Doctor Paxton explained. "We need to reach the woman, or man, in the street who doesn't have the health insurance that so many of us take for granted, or youngsters in rural areas whose access to quality health care is as non-existent as health care for children of the inner-city."

It comes as no surprise that Federal and State aid doesn't reach into all the nooks and crannies of Michigan. Washington and Lansing can do only so much. In recent years, legislative cut-backs have hurt quality health assistance programs.

"As the economic belt continues to tighten," said Doctor Paxton, "resources of the private sector become more and more important. HEF Board members know which way the legislative winds blow."

The Foundation is, of course, legally prohibited from influencing legislation as it wends its way through the hallways and committee rooms of the Capitol, but HEF Board members are a savvy and knowledgeable group who pay attention to the political climate, and to where the budget axe swings. They fully understand that as times change, HEF must change. "The Board has a real-world view of medicine," Doctor Paxton said. "They're informed, and they make good decisions about who gets money."

Health programs key target

Just as important, the Board understands the practice of medicine and focuses on clinical, sociological, and economic health care issues. Other foundations support a variety of projects, but HEF specializes in health issue programs. The net effect is that the Board appreciates the subtleties and nuances of medicine that other foundations can't hope to match.

"We have to be specialists in allocating our funds," Doctor Paxton argued. "Like everything else, grant-giving is more complicated than it used to be." Doctor Paxton understands that physicians find it tough to be interested in altruistic goals when they have to spend so much of their time and energy solving the day-to-day problems of running a practice.

Aware of that dilemma, MSMS developed Physician Service Group, Inc., to supply members with products and services that meet their business needs. "PSG is working," Doctor Paxton said. "HEF addresses gift-giving problems the same way as PSG approaches business problems — with specialists who make solid recommendations for the best course of action."

The Health Education Foundation doesn't pretend to be one of the gift-giving giants. "Competing foundations make a good case when they solicit money from our members," Doctor Paxton said candidly. "But they can't promise that contributions will go to the health care projects our members care about. We can — and do — make that promise because health care is our only focus."

"The Foundation also functions as an intermediary for our members," Doctor Paxton continued. "When members contribute individually to worthy projects, it's difficult to have much effect. But when they contribute to HEF, their dollars are combined with the contributions of others. It's HEF's job to see that our grants have an impact, and it makes good economic sense that dollars combined with other dollars go farther. If all the members who now contribute to one organization or another made their donations to the Foundation instead, think of what we could do. Just imagine the impact MSMS contributions would have if they went to a few carefully selected projects rather than being spread so thin."

In the last three years, grants have been awarded to the Michigan Health Council to support a physician placement service, to Michigan State University's Department of Family Practice for a study of lipid lowering in primary care, and to the Department of Pediatrics at the University of Michigan. "These are worthwhile projects," Doctor Paxton commented, "and our members would confidently support any of them. But how many physicians have the time to study each project the way the Board does?"

Take a look at HEF

"I want our members — all 11,000 of them — to take a close look at what HEF is doing," he urged. "I know it'll be the first time many of them have done that."

True enough, but MSMS members are not the only folks unfamiliar with philanthropic organizations. According to a recent Gallup survey on volunteerism and philanthropy, more and more Americans are ready to give their time and money. However, results of the survey released last fall clearly show that most people don't participate because they're not asked. Even if they are sufficiently motivated to help, they often don't know where to go or whom to contact. Many local communities have no group or committee responsible for giving and volunteering.

At HEF, Doctor Paxton is working to combat that kind of communications breakdown. "We've even formed a subcommittee of the Board charged with the responsibility of getting the word out about the Foundation," he said. The committee will explore effective ways to increase visibility for the projects and programs the Foundation supports both with members and the general public. It also will examine fund-raising objectives.

"To be frank about it, we're doing good work," said HEF President Paxton. "We're really helping people where they live. I'm proud of that, and I'm eager to talk about it. HEF offers our physicians a sound alternative."

In fact, the mission statement of HEF captures the essence of the Foundation and its philosophy. The purpose of HEF, it reads, is "to advance the field of health for the public good." "Isn't that clear and to the point?" Doctor Paxton asked rhetorically. "Isn't that why we're physicians?"

The statement also describes how HEF is a "vehicle for the Michigan State Medical Society to foster humanitarian public service." There is no doubt that physicians spend much energy each day laboring on behalf of the public good, but as the mission statement suggests, HEF offers another avenue for that desire to help.

Michigan is a magnificent state with abundant opportunity for work and play. Underneath, it is a network of communities filled with people, and one of the common threads that draws these communities together is quality health care. In Detroit or Traverse City, Escanaba or Battle Creek, the goal is the same for the physicians who deliver health services and for the recipients of those services.

"We're all in this together," Doctor Paxton declared. "Those of us who practice medicine belong to a very special profession with unique obligations to that profession and to our communities. We have a moral responsibility as physicians that can't be denied. The HEF Board knows that the projects we support demonstrate our willingness to accept that responsibility.

"If the Board accepts that responsibility, MSMS members also must accept it. If the people of Michigan live healthier, happier lives because of the programs we support, we're all better off. When our members know more about the Foundation, they'll appreciate why our approach works so well. Remember, the Health Education Foundation doesn't only *represent* MSMS members, it *is* the members." ■

Peter Marabell, a Michigan State University professor, is a freelance writer and is general manager of GPM Communications, East Lansing.

MAKING A DIFFERENCE…

The purpose of the Health Education Foundation is to advance the field of health for the public good. The mission of the Foundation is to achieve the following:

- Stimulate, support, and/or initiate lay or professional education, research programs, and projects in the field of health.

- Encourage the advancement of healthy lifestyles, prevention, diagnosis, or cure of disease, and the care of the sick and the dying.

- Provide a vehicle for the Michigan State Medical Society to foster humanitarian public service in health education and research, and

- Provide a resource for the management and distribution of signature funds or bequests designated for special health education and research purposes.

For additional information or to make a contribution, please contact
Amy C. Fistler, Executive Secretary, at Michigan State Medical Society.
(517) 337-1351

Sponsored by Michigan State Medical Society
120 West Saginaw, East Lansing, Michigan 48823

Health
Education
FOUNDATION

MSMS to Hold Second Annual Seminar for Young Physicians

Nearly 100 young physicians and senior residents from around the state gathered in Dearborn last October for the first annual seminar on financial and medical practice management. The workshop featured seven educational sessions and speakers.

The MSMS Young Physicians Section, in cooperation with Physician Service Group, Inc., an MSMS subsidiary, will hold their Second Annual One-Day Seminar on Financial and Medical Practice Management, Friday, September 29, at Henry Ford Hospital, Detroit.

The day will consist of five 45-minute sessions on a variety of topics aimed primarily at the physician just setting up practice. A question and answer period will follow each session.

Morning sessions will include:

(1) **Keeping Up With Current Health Law and Legislation.** This session will address the importance of keeping informed on current legal and legislative issues and how it effects the day-to-day practice of medicine. Included in this will be issues dealing with tax laws in both the professional and personal life of the physician. Other topics will include important Michigan legislative developments such as the new HIV and communicable disease laws, physician licensure, and medical waste management laws on both the state and national levels. Featured speaker will be Monte D. Jahnke, partner with Kerr, Russell & Weber, Detroit.

(2) **Meeting Today's Challenges.** This session will focus on the challenges facing physicians entering the medical field including, but not limited to, third party reimbursement, patient concerns, and practice management. Included in this discussion will be the important role of organized medicine and the advantages of taking an active part in county, state and national organizations. Featured speaker for this session will be Susan H. Adelman, MD, MSMS president-elect.

Afternoon sessions will include:

(1) **Financial Management Techniques for Personal and Professional Use.** This session will discuss how to prepare loan applications for personal or professional use. Also, the session will discuss how to handle the debt load associated with starting a medical practice along with the student loans that have been accumulated while in medical school. Featured speaker for this session will be Barbara Haber, private banking officer for Comerica Bank, Detroit.

(2) **Advantages of Buying or Leasing Medical Equipment.** This session will examine how to obtain specialized medical equipment to offer specialized services, or automated equipment to help manage your business. The issue of when to lease and when to buy will be explored as well as several other timely topics associated with this question. Featured speaker for this session will be Mike Stephen, vice president, State Medical Association Programs, Bell Atlantic-TriCon.

(3) **Practice Marketing Techniques.** This session will explore how physicians can build their practices, ethically, to maximize their patient load as soon as possible. Topics to be discussed include the professional and economic prospects of your community, defining your marketing objectives and using advertising in the medical practice. Featured speaker for this session will be Linda Buck, vice president of Marketing Services, Medical Marketing Products, Inc.

Registration for the one-day seminar is $50 per person for MSMS members, $75 for non-members, $20 for MSMS resident physician members, and $35 for non-member resident physicians. Registration fee includes seminar materials, refreshments and luncheon.

To register, or for more seminar information, contact Linda Munson, MSMS-YPS staff liaison, at (517) 337-1351. ■

MSMS Presents Young Physicians' Seminar

The **Michigan State Medical Society's Young Physicians Section** in cooperation with our subsidiary **Physician Service Group, Inc.**, is pleased to announce their Second Annual One-Day Seminar tailored for young physicians and senior residents on **Financial and Medical Practice Management.**

Date: *Friday, September 29, 1989*
Location: *Henry Ford Hospital—West Grand Boulevard, Detroit*
Time: *8:30 a.m. to 4:00 p.m.*

Who Should Attend: This seminar will help you learn the practical techniques used by physicians in every discipline of medicine. The instructors have been carefully selected, and they have an excellent knowledge of the management techniques that you didn't learn in medical school. What you learn in this seminar, you will use in your practice. This seminar would be beneficial and is available to any age physician.

PROGRAM

8:30 a.m.	Registration with Coffee, Juice and Rolls
9:00 a.m.	Introduction by MSMS-YPS Governing Council member with a presentation on Michigan Liability Insurance by MPMLC & PICOM
10:30 a.m.	Keeping Up With Current Health Law and Legislation
11:15 a.m.	Meeting Today's Challenges
1:15 p.m.	Financial Management Techniques for Personal and Professional Use
2:15 p.m.	Advantages for Buying or Leasing Medical Equipment
3:00 p.m.	Practice Marketing Techniques

(Question and Answer time will be available with all speakers)

Registration Fee includes seminar hand-out materials; luncheon and refreshment breaks.

For more information, call Linda Munson at MSMS Headquarters (517) 337-1351

Please register me for the MSMS September 29 Financial and Practice Management Seminar

Name ________________________

Address ________________________

City ____________ **State** ______ **Zip** ______

Phone ________________________

Circle if you are a member or non-member physician or resident.

MSMS Physician Member	**$50**
Physician Non-Member	**$75**
MSMS Resident Physician Member	**$20**
Resident Physician Non-Member	**$35**

Enclose check payable to Michigan State Medical Society and mail to: Physician Service Group, Inc., 120 W. Saginaw, East Lansing, MI 48826-0950. Attn: Julie Morse

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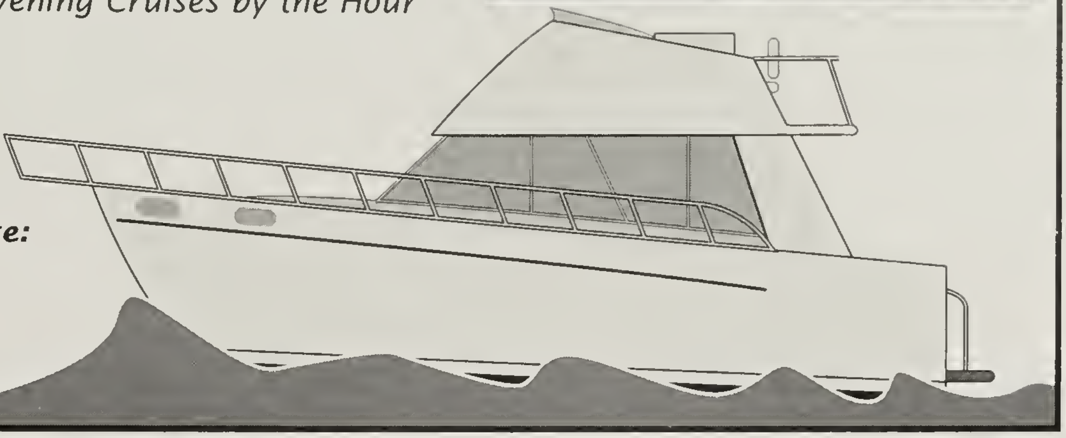

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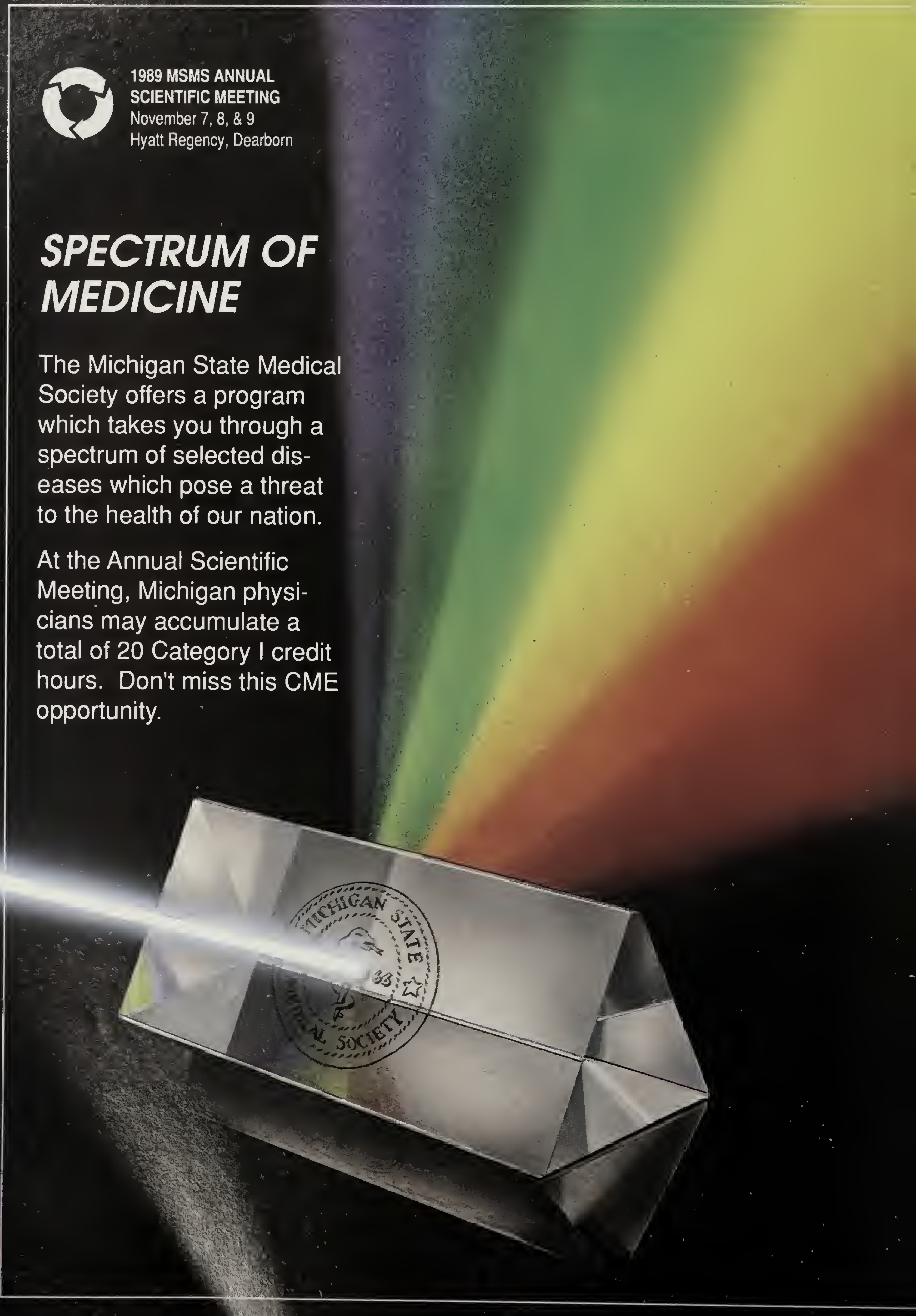

1989 MSMS ANNUAL
SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

SPECTRUM OF MEDICINE

The Michigan State Medical Society offers a program which takes you through a spectrum of selected diseases which pose a threat to the health of our nation.

At the Annual Scientific Meeting, Michigan physicians may accumulate a total of 20 Category I credit hours. Don't miss this CME opportunity.

MSMS Annual Scientific Meeting Covers Spectrum of Medical Challenges

By Joan C. Stryker, MD, Chairman

Doctor Stryker

The spectrum is the key to the 1989 MSMS Annual Scientific Meeting—symbolizing today's wide-ranging challenges to the Michigan physician, and hence the broad scope of topics offered.

This year, Planning Committee members have striven to bring you courses which take an encompassing view—tackling medical issues which cut across all specialties and affect all patients.

We have selected diseases and conditions which pose a threat to the health of our nation, and which provide opportunities for physicians to take a large role in affecting all of society.

Hepatitis B, drug abuse, weight loss, violence in families, the environment, childhood depression, AIDS—these are some of the broad-spectrum topics which our speakers will bring to you.

I am pleased and proud to serve as Annual Scientific Meeting chairman for the second year, and to have led the talented and knowledgeable Committee members who have planned the meeting.

The dates are November 7-9 and the setting again is the Hyatt Regency Dearborn, with its excellent facilities and easy access for travelers.

This year we will present two "early bird" plenary sessions, open to all meeting attendees, beginning with continental breakfast at 7 a.m. Wednesday and Thursday mornings.

The first is on hepatitis B. The speaker will be Sanford Kuvin, MD, vice chairman, National Foundation for Infectious Diseases, Washington, DC. Doctor Kuvin's premise is that hepatitis B is "the most important chronic blood-borne disease in the world," overshadowing AIDS.

The second plenary session is on drug abuse as a serious threat to the general health of the country. Speaker will be Beny J. Primm, MD, executive director, Addiction Research and Treatment Corporation, Brooklyn. He will discuss how abuse of cocaine—particularly its potent version, crack—affects so many aspects of health care today.

The plenary sessions are free to all attending the meeting, and will offer one Category 1 credit hour each.

Through attendance at the Annual Scientific Meeting, Michigan physicians may accumulate a total of 20 Category 1 credit hours, four-fifths of the required total for the year.

The committee again has approved poster presentations for display in the main corridor of the meeting. Authors will be on hand to discuss their findings. Judging of the posters will take place the first day of the meeting, so that viewers may share the winners' success throughout the meeting.

Among the special events planned concurrently with the Annual Scientific Meeting are the receptions sponsored by the alumni associations of the medical schools at Michigan State University and Wayne State University.

In these pages you will find the list of courses, course directors and speakers, the schedule of special events, list of exhibitors and tear-off registration form. In addition, by using the early hotel reservation card bound in this issue, you will be eligible to win free lodging and dinner for two during the meeting.

Please also watch for the October Michigan Medicine "convention special," which will provide more information to help you plan your stay in Dearborn.

I look forward to greeting you personally at the meeting. Come to Dearborn to study the spectrum of medical care issues!

Capsule Schedule of Annual Scientific Meeting

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

TUESDAY, NOVEMBER 7

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Concurrent Scientific Courses *(run until Noon)*
- Depressive Disorders
- Basic Cardiac Life Support
- Congestive Heart Failure
- Critical Care
- Magnetic Resonance Imaging
- Industry & The Environment
- Pain Control for Terminal Cancer
- Ear Problems
- New Arthritides

Clinical Poster Display *(all day)*

12 Noon
Luncheon for All Registrants

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*
- Breast Cancer
- High Risk Patient
- Childhood Depression
- Gastrointestinal Surgery
- Physician-Patient Relationships
- Orthopaedics in Family Practice
- Perioperative Risk Management
- Safe Weight Loss
- Eye and Systemic Disease
- Ethics

6:00 PM
Reception
MSMS ASM Planning Committee

WEDNESDAY, NOVEMBER 8

7:00 AM
"Early Bird" Plenary Session on Drug Abuse
Hubbard Ballroom *(Coffee & Rolls included)*

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Clinical Poster Display *(all day)*
Concurrent Scientific Courses *(run until Noon)*
- Antimicrobial Therapy
- Basic Cardiac Life Support
- Poisonings and Overdoses
- Hypercholesterolemia
- New Reproductive Technologies
- Primary Care for Women
- Adolescent Patients
- Sleep Disorders
- Accidental Geriatrician

9:00 AM
Board Meeting/Luncheon
Michigan Allergy Society

12 Noon
Lunch for All Registrants
Luncheon
MSMS Committee on Concerns of Women Physicians
Luncheon
MSMS Specialty Society Presidents

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*
- Allergy and Asthma
- Colorectal Cancer
- Dermatology
- Fertility and Pregnancy at 35
- Environment and Illness
- Thyroid Disease
- Radiology
- Sexuality
- Aging Gut
- Urology

3:00 PM
Board Meeting/Reception/Dinner/Program
Michigan Orthopaedic Society

6:00 PM
Reception
Michigan State University College of Human Medicine Alumni Association
Reception
Wayne State University Medical Alumni Association

6:30 PM
Reception/Dinner
Physician Service Group, Inc.

THURSDAY, NOVEMBER 9

7:00 AM
"Early Bird" Plenary Session on Hepatitis B
Hubbard Ballroom *(Coffee & Rolls included)*

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Concurrent Scientific Courses *(run until Noon)*

- Acute MI
- Basic Cardiac Life Support
- ENT in Children
- Falls in the Elderly
- Leg/Back Pain
- Neurology
- Maxillofacial Reconstruction
- Ulcer Disease
- Trauma Education

12 NOON
Lunch for All Registrants

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*

- Brain and Heart
- Plastic Surgery
- Electrolyte and Acid Base Problems
- Patients on Workers Compensation
- Psychoactive Drug Use & Misuse
- HIV Positive Patient
- Violence Within Families
- Sinus Disease

6:00 PM
Reception/Dinner/Meeting
Michigan College of Nuclear Medicine Physicians

Schedule of Special Events

☐ **Clinical Poster Displays** *(all day)*
Tuesday and Wednesday,
November 7-8

☐ **"Early Bird" Plenary Sessions I and II**
Hubbard Ballroom
(Coffee & Rolls included)
Wednesday, November 8 at 7 a.m.
Thursday, November 9 at 7 a.m.

☐ **MSMS ASM Planning Committee**
Reception
Tuesday, November 7 at 6:00 p.m.

☐ **MSMS Committee on Concerns of Women Physicians**
Luncheon
Wednesday, November 8 at 12:00 Noon

☐ **MSMS Committee of Specialty Society Presidents**
Luncheon
Wednesday, November 8 at 12:00 Noon

☐ **MSMS Physician Service Group, Inc.**
Reception/Dinner
Wednesday, November 8 at 6:30 p.m.

☐ **Michigan Allergy Society**
Board Meeting at 9:00 a.m.
Luncheon at 12:00 Noon
Wednesday, November 8

☐ **Michigan College of Nuclear Medicine Physicians**
Reception/Dinner/Meeting
Thursday, November 9 at 6 p.m.

☐ **Michigan Orthopaedic Society**
Board Meeting/Reception/
Dinner/Program
Wednesday, November 8 at 3 p.m.

☐ **Michigan State University College of Human Medicine Alumni Association**
Reception
Wednesday, November 8 at 6:00 p.m.

☐ **Wayne State University Medical Alumni Association**
Reception
Wednesday, November 8 at 6:00 p.m.

Plan to Visit These Firms' Exhibits

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting November 7, 8, & 9 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be there to discuss the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the Annual Scientific Meeting and is the site of registration for all courses and special events. In addition, the deli luncheons and refreshments during breaks are served in the exhibit area.

To help you plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

☐ PHARMACEUTICALS

- Boehringer Ingelheim Pharmaceuticals, Inc.
- DuPont Pharmaceuticals
- Allen & Hanburys (Division of Glaxo, Inc.)
- Janssen Pharmaceutica
- McNeil Consumer Products Company
- Merck Sharp & Dohme
- Parke-Davis
- Pfizer Laboratories Division
- Princeton Pharmaceutical Products
- Purdue Frederick
- A.H. Robins Company
- Schering Corporation
- Smith Kline & French Laboratories
- E.R. Squibb & Sons, Inc.
- The Upjohn Company
- Wyeth-Ayerst Laboratories

☐ CLINICAL LABORATORIES

- Advance Medical/MetPath
- Continental Bio-Clinical Laboratory Service, Inc.
- Eagle Associates
- Healthcare Laboratories, Inc.

☐ IN-OFFICE EQUIPMENT AND SUPPORT

- Bell Atlantic TriCon Leasing Corporation
- Brentwood Instruments, Inc.
- Cellular One
- I.C. Systems, Inc.
- Tri State Hospital Supply Corp.

☐ PATIENT HOME CARE

- Rehabilitation Network

☐ COMPUTERS COMPUTER SERVICES

- Bennethum Computer Systems
- Colonial Valley Software, Inc.
- CRT Management
- Diversitec/Blue Cross & Blue Shield
- Hewlett Packard
- Medical Billing Service
- Office Technologies, Inc.
- Professional Practice Sales
- Scientific Data Management Medical Computer Systems
- Versyss Corporation

☐ EDUCATIONAL RESOURCES

- J. B. Lippincott Company
- W. B. Saunders

☐ PROTECTION

- Blue Cross & Blue Shield of Michigan - Automated Input Concepts
- Blue Cross & Blue Shield of Michigan - Field Services
- Comerica Bank
- Disability Determination Service
- The Equitable - Association Members Retirement Program
- Michigan Physicians Mutual Liability Company
- Physicians Insurance Company of Michigan
- Physicians Service Group, Inc.
- Professional Asset Management, Inc.
- Retirement Plan Consulting Group
- Shearson Lehman Hutton
- Stratton Cheeseman & Associates
- Stratton Cheeseman Management Company, Inc.

☐ OTHER EXHIBITORS

- Henry Ford Hospital and Medical Centers
- Randolph Medical, Inc.
- University of Michigan Medical Center
- Wyandotte Hospital and Medical Center

1989 MSMS ANNUAL
SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

Registration Form

ame ____
lease print) (first) (intial) (last)

treet ____

ity ________________________ State ________ Zip __________

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HOOSING YOUR COURSES

lease check the courses you wish to attend. In each case, **please indicate a second choice** should the first already be filled. Maximum tendance figures have been set for each course, depending on room size.

Tuesday Morning, November 7

(8:30 to Noon, including break)

Write 1 in blank for first choice and 2 for second choice)

_ Assessment and Treatment of Depressive Disorders
_ Basic Cardiac Life Support
_ Congestive Heart Failure: Update on Diagnosis & Treatment
_ Critical Care: Practical Points for the Primary Care Physician
_ Current Status of Magnetic Resonance Imaging and Spectroscopy
_ Industry & The Environment
_ Pain and Symptom Control for Patients with Advanced or Terminal Cancer
_ Review of Ear Problems
_ The New Arthritides

Wednesday, November 8

(7:15 - 8:15 AM, *No Fee*)

___ "Early Bird" Plenary Session on Drug Abuse (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Antimicrobial Therapy
___ Basic Cardiac Life Support
___ Emergency Management of Poisonings and Overdoses
___ Hypercholesterolemia: From Eight to Eighty
___ Methods and Ethics of New Reproductive Technologies
___ Primary Care for Women
___ Screening & Prevention in Adolescent Patients
___ Sleep Disorders in Primary Care Medicine
___ The Accidental Geriatrician

Thursday, November 9

(7:15 - 8:15 AM, *No Fee*)

___ "Early Bird" Plenary Session on Hepatitis B (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Acute MI from ER and Beyond
___ Basic Cardiac Life Support
___ Common ENT Problems in Children
___ Falls in the Elderly
___ Leg and/or Back Pain and Dysfunction: Diagnosis and Management
___ New Neurology - The Common and The Uncommon
___ Priorities In Maxillofacial Reconstruction
___ The Spectrum of Ulcer Disease - 1989
___ Trauma Education Programs for Primary Care Physicians

deli sandwich will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please dicate which days you want a lunch ticket.

Tuesday lunch ☐ Wednesday lunch ☐ Thursday lunch ☐

Tuesday Afternoon, November 7

(1:30 to 5:00, including break)

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_ Breast Cancer: Diagnosis and Management
_ Care of the Medical/Social High-Risk Patient: Newborn to Infant
_ Childhood Depression: A Family Affair
_ Gastrointestinal Surgery for the Non-Surgeon
_ Managing Difficult Physician-Patient Relationships
_ Orthopaedics in Family Practice
_ Perioperative Risk Management in Surgery and Obstetrics
_ Safe Weight Loss
_ The Eye as a Window to Systemic Disease
_ Update on Ethics: Three Current Concerns

Wednesday Afternoon, November 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Allergy and Asthma Update: 1989
___ Colorectal Cancer - The Silent Epidemic
___ Dermatology: Melanoma 1989
___ Fertility and Pregnancy at 35 - Plus: Is it Different?
___ Is My Environment Making Me Sick, Doctor?
___ Optimizing Thyroid Disease Diagnosis
___ Radiology for Clinicians
___ Sexuality and Sexual Problems
___ The Aging Gut
___ What's New in Urology

Thursday Afternoon, November 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Brain and Heart: 1989
___ Clinical & Research Studies in Common Plastic Surgery Problems
___ Current Concepts in the Management of Electrolyte and Acid Base Problems
___ Management of Your Patient on Workers Compensation
___ Psychoactive Drug Use & Misuse: A Psychiatric/Medical Controversy
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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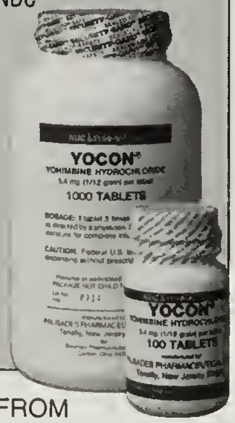

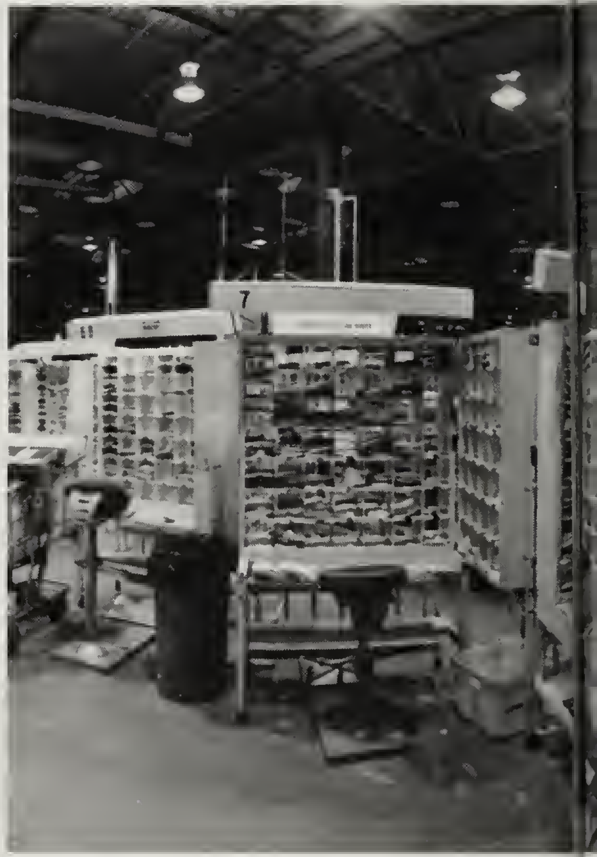

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1. For the treatment of patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis. If hypokalemia is the result of diuretic therapy, consideration should be given to the use of a lower dose of diuretic, which may be sufficient without leading to hypokalemia
2. For the prevention of hypokalemia in patients who would be at particular risk if hypokalemia were to develop, e.g., digitalized patients or patients with significant cardiac arrhythmias.

The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern and when low doses of the diuretic are used. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases, and if dose adjustment of the diuretic is ineffective or unwarranted, supplementation with potassium salts may be indicated.

CONTRAINDICATIONS Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene, amiloride) (see **OVERDOSAGE**).

Controlled release formulations of potassium chloride have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium. Potassium supplementation, when indicated in such patients, should be given as a liquid preparation or as an aqueous (water) suspension of K-DUR (see **PRECAUTIONS, Information for Patients,** and **DOSAGE AND ADMINISTRATION** sections).

All solid dosage forms of potassium chloride are contraindicated in any patient in whom there is structural, pathological (e.g., diabetic gastroparesis) or pharmacologic (use of anticholinergic agents or other agents with anticholinergic properties at sufficient doses to exert anticholinergic effects) cause for arrest or delay in tablet passage through the gastrointestinal tract.

WARNINGS Hyperkalemia (see **OVERDOSAGE**)—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone, triamterene or amiloride) since the simultaneous administration of these agents can produce severe hyperkalemia.

Interaction with Angiotensin Converting Enzyme Inhibitors—Angiotensin converting enzyme (ACE) inhibitors (e.g., captopril, enalapril) will produce some potassium retention by inhibiting aldosterone production. Potassium supplements should be given to patients receiving ACE inhibitors only with close monitoring.

Gastrointestinal Lesions—Solid oral dosage forms of potassium chloride can produce ulcerative and/or stenotic lesions of the gastrointestinal tract. Based on spontaneous adverse reaction reports, enteric coated preparations of potassium chloride are associated with an increased frequency of small bowel lesions (40-50 per 100,000 patient years) compared to sustained release wax matrix formulations (less than one per 100,000 patient years). Because of the lack of extensive marketing experience with microencapsulated products, a comparison between such products and wax matrix or enteric coated products is not available. K-DUR is a tablet formulated to provide a controlled rate of release of microencapsulated potassium chloride and thus to minimize the possibility of a high local concentration of potassium near the gastrointestinal wall.

Prospective trials have been conducted in normal human volunteers in which the upper gastrointestinal tract was evaluated by endoscopic inspection before and after one week of solid oral potassium chloride therapy. The ability of this model to predict events occurring in usual clinical practice is unknown. Trials which approximated usual clinical practice did not reveal any clear differences between the wax matrix and microencapsulated dosage forms. In contrast, there was a higher incidence of gastric and duodenal lesions in subjects receiving a high dose of a wax matrix controlled release formulation under conditions which did not resemble usual or recommended clinical practice (i.e., 96 mEq per day in divided doses of potassium chloride administered to fasted patients, in the presence of an anticholinergic drug to delay gastric emptying). The upper gastrointestinal lesions observed by endoscopy were asymptomatic and were not accompanied by evidence of bleeding (Hemoccult testing). The relevance of these findings to the usual conditions (i.e., non-fasting, no anticholinergic agent, smaller doses) under which controlled release potassium chloride products are used is uncertain; epidemiologic studies have not identified an elevated risk, compared to microencapsulated products, for upper gastrointestinal lesions in patients receiving wax matrix formulations. K-DUR should be discontinued immediately and the possibility of ulceration, obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS General: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: When blood is drawn for analysis of plasma potassium it is important to recognize that artifactual elevations can occur after improper venipuncture technique or as a result of in-vitro hemolysis of the sample.

Drug Interactions: Potassium-sparing diuretics, angiotensin converting enzyme inhibitors (see **WARNINGS**).

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity and fertility studies in animals have not been performed. Potassium is a normal dietary constituent.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is unlikely that potassium supplementation that does not lead to hyperkalemia would have an adverse effect on the fetus or would affect reproductive capacity

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**).

The most common adverse reactions to oral potassium salts are nausea, vomiting, flatulence, abdominal pain/discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by diluting the preparation further, taking the dose with meals or reducing the amount taken at one time.

OVERDOSAGE The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of any agents with potassium-sparing properties.
2. Intravenous administration of 300 to 500 mL/hr of 10% dextrose solution containing 10–20 units of crystalline insulin per 1,000 mL.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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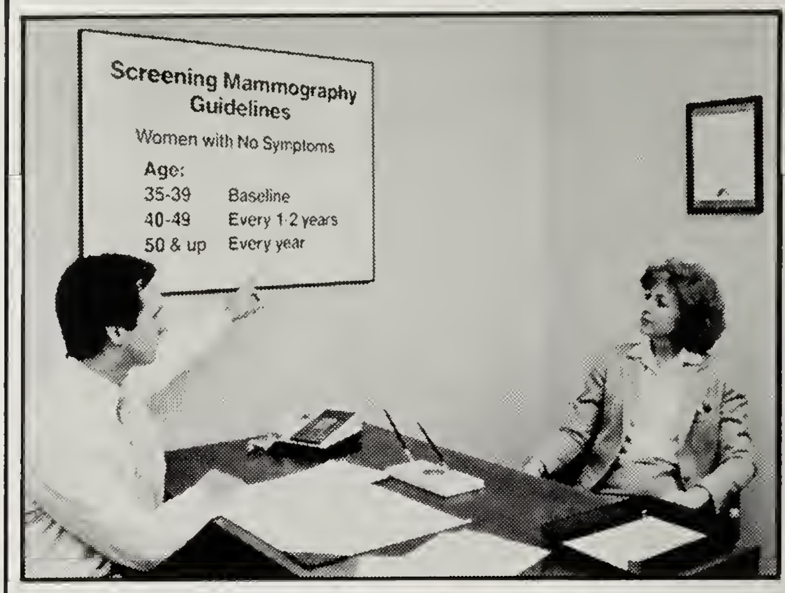

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A Tough Future for Medicine

By Marianne Udow

Editor's note: *Marianne Udow, vice president, Planning & Development Services, Blue Cross Blue Shield of Michigan, spoke about the future of medicine at the MSMS Midsummer Board of Directors meeting held July 13-15 at Shanty Creek. Following are highlights of her presentation.*

I intend to cover three major areas in my talk. First, I will talk about the pressures that I see on the health care delivery system over the next five to 10 years. Second, I will do some prognosticating about the outcomes I expect are likely as a result of those pressures. Finally, I will cover potential directions I think the medical community can take in light of these outcomes.

Before I begin, let me warn you that much of what I have to say may sound like a tough future for medicine. I hope that by the conclusion, however, you see some ways to make the future work for you and your patients.

Pressures on the system

I see the pressures of the 1990s as threefold.

First, the *cost pressure will intensify*. Overall estimates on health care costs suggest that by the year 2000, the percentage of GNP devoted to health care will go from the current level of just over 11 percent to approximately 15 percent. Perhaps stated more dramatically, our rate of expenditures will go from the current level of $559 billion to $1.5 trillion in less than 11 years. Some of the factors that are driving those cost increases — AIDS, drug and alcohol addiction and related crime, and increasingly disrupted families in our inner cities — will place tremendous stress on our public health care system. In addition, the growth of the old old population (those 75 years and older) with the concomitant powerful senior lobby acting to maintain (and even expand) health benefits, will place powerful pressures on the governmental funding system. Also, expansion of technology will make this population group (as well as the very ill in younger populations) much more likely to survive with increased morbidity. It is no surprise, then, that the Medicare trust fund is expected to be bankrupt by the year 2005. Finally, I don't know that American business will accept that rate of increase in health care costs quietly. In a recent survey in Crain's, 36 percent of the surveyed CEOs felt that the most important issue over all others they are facing is the need to contain health care costs. Eight-four percent felt that controls on health care costs are necessary in order to improve the Michigan business climate.

Second, the societal pressure for *universal coverage* will intensify. The combination of advocates from big business and those who have historically viewed health care as a right is a powerful force pushing for some sort of universal coverage. The same pressures that were present in the 19th century for universal public education are here today with regard to health care. Rightly or wrongly, these advocates have looked around the world and compared their health care costs in the US with those they experience in other countries and have concluded that universal health care could be offered more equitably and at lower cost than our current system of mixed private-public and no coverage.

Third, and finally, the *attitudes of the American public* toward our current

Continued on page 54

Continued from previous page

health care delivery system is a pressure that will be reflected in the policy decisions of the 1990s. Recent opinion polls have indicated that the American public is not as satisfied with our health care delivery system as are the British or Canadian publics with their systems. In a Lou Harris poll conducted late last year, almost 90 percent of Americans expressed strong dissatisfaction with the current health care system compared to 44 percent of Canadians and 73 percent of British. While the reasons for that dissatisfaction are not entirely clear, the flexibility and, in fact, support that view gives to policy makers to make significant changes to the current system are important to understand.

Predictions

There is one overriding statement I would like to make about where we are headed. Over the next 10 to 15 years, health care will no longer be taken as an absolute good. Rather, health care will be looked at as an important service that is in competition with other services for our limited resources. That statement has profound implications for you as practitioners. What that means is that cost pressures will increasingly intrude on medical decisions. Such pressures are certainly already there. However, decisions in this regard will become more explicit rather than implicit as they are for the most part today.

I believe that over the next 10 years, our society, through the political process, will begin to ask trade-off questions such as this: Do you want to live in a society with the best possible health care for everyone but a mediocre educational system or do you want to live in a society with a good, basic health care system but an excellent educational system? I don't have the answer, but we must understand that this a real question — one that is being dealt with implicitly today; one that will, that must, become increasingly explicit given our limited resources.

I do not believe that within the next five to 10 years we will move to a government-run health care delivery or financing system like either the Canadian or British models. I do believe we will move to a system like some states now have in place — mandated benefits for employers with some government benefit programs expanding to cover the non-working uninsured. What that means is that, in the short run at least, we will have an increasingly administratively complex system of health benefits with multiple payers involved. The multiplicity of payers will bring with them additional attempts at bureaucratic solutions to the cost problems while still maintaining broad benefit coverage.

Responses

I have already identified three major pressures on the system, so let me suggest three possible responses or directions to consider.

First and perhaps foremost, it is critical that physicians are involved in shaping whatever direction the health care delivery system takes. The pressures I have described are so great; the economic, political and social direction is becoming so well formed that change will occur — with or without physician participation in the process. I am concerned about what kind of system might develop if physicians take a purely obstructionist view and if decisions are left solely to bureaucrats like me. Physician participation is essential to help protect patients, minimize the need for and approach to bureaucratic intrusions as well as to lead the debate when our culture becomes explicit about the trade-offs we face. I know from having worked with many physicians that they agree with me on the importance of physician involvement. What I want to say to you today is that the issues will get tougher and I hope none of you will give up the faith that your efforts can make a difference.

Second, and this is a prediction not a recommendation, I believe that those of you who want to practice medicine exclusively and be involved as little as possible in the business or administrative end of medicine will need to increasingly look toward group practice or linkages with health care delivery organizations, such as hospitals, as a vehicle to support the delivery of care. It is through those vehicles that the business end of the practice can be managed.

Finally, let me suggest that you must work together to develop some response to the approach to universal health coverage. As I said, I believe all of the forces are in place to make universal coverage (at least of limited form) a reality within the next five to 10 years. Arnold Relman has certainly recognized that direction and has promoted open debate within *The New England Journal of Medicine* on the form such coverage could take. I strongly recommend to each of you that you take that direction seriously and consider what kind of a system would be best to allow you to do what I think most of you would most like to do — practice medicine. ■

Marianne Udow is vice president, Planning & Development Services, for Blue Cross Blue Shield of Michigan.

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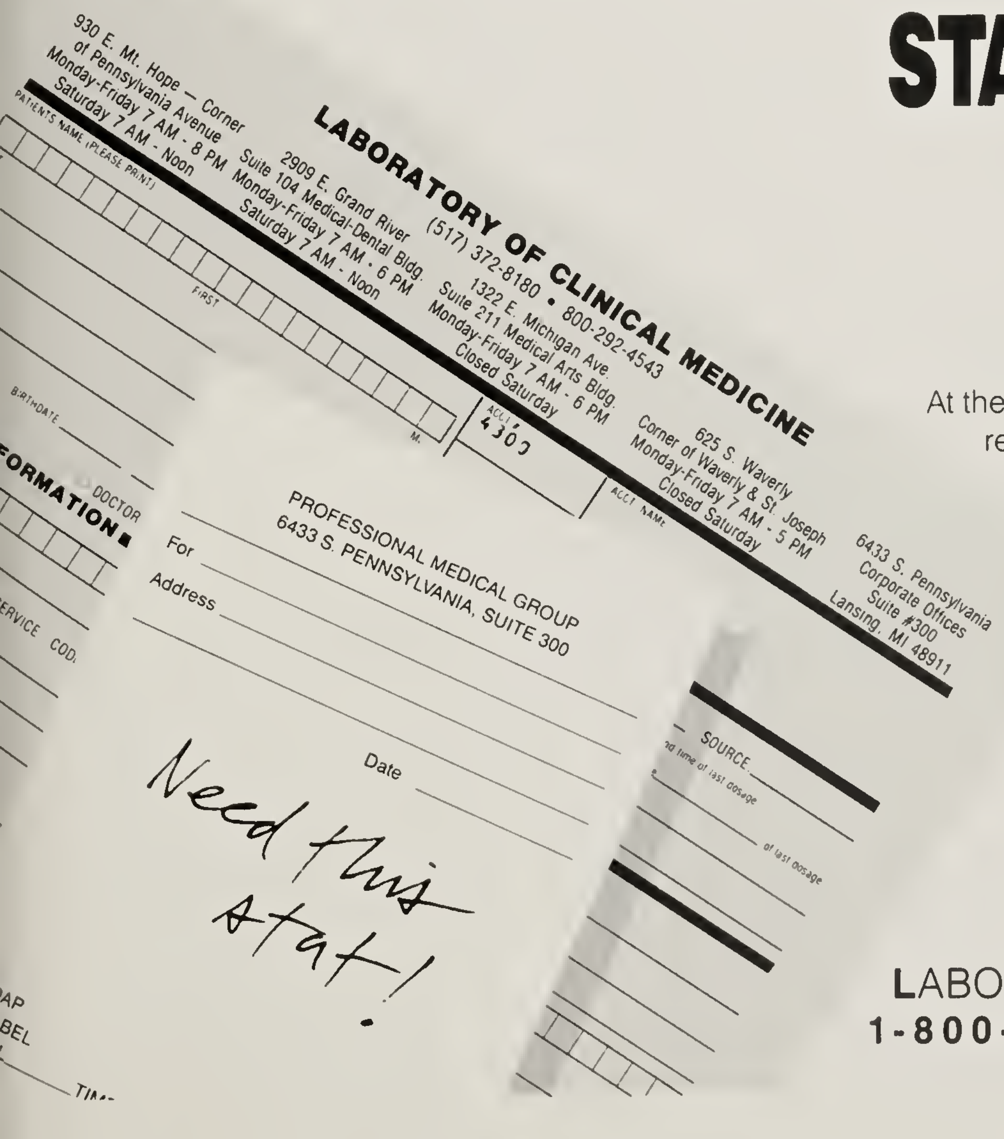

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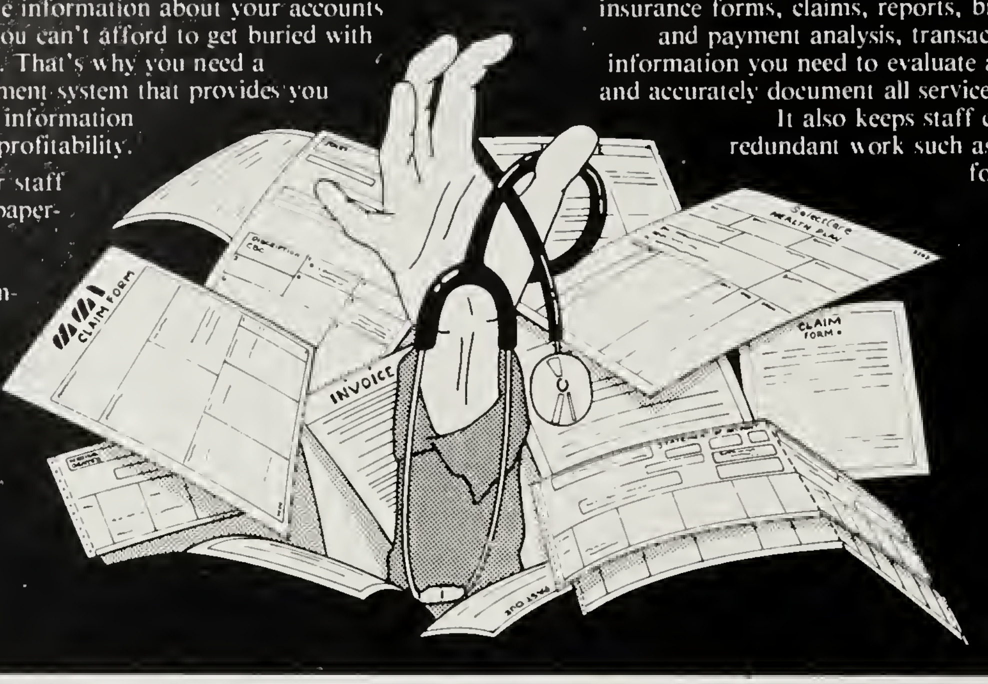

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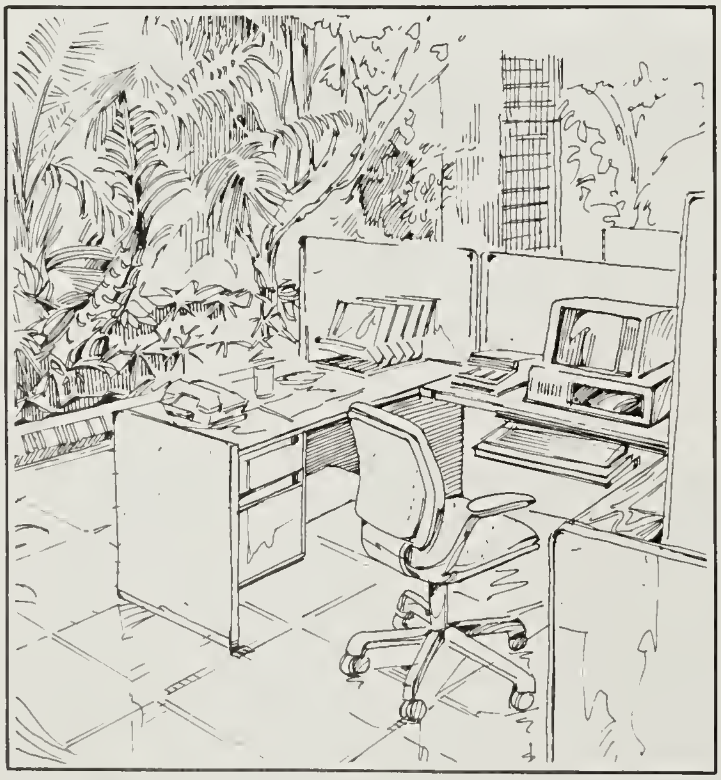

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MEETINGS

MSMS Meetings

September

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

20, MSMS/PSG Starting Yourself in Medical Practice Seminar, Amway Grand, Grand Rapids, Michigan. Contact: Amy Fistler, (517) 337-1351. Ext. 65.

26, MSMS Public Affairs/Leadership Conference, Lansing Radisson, Lansing, Michigan, Contact: Mary Anne Ford, MSMS Chief, State Government Affairs, (517) 337-1351.

27, MSMS Section for Graduates of Foreign Medical Schools/Enhancing Your Public Image, Clarion Hotel, Lansing, MI. Contact: Judy Marr, MSMS/GFMS Staff Liaison, (517) 337-1351.

29, MSMS Young Physicians' Seminar, Ford Hospital, Detroit. Contact: Linda Munson, MSMS/YPS Staff Liaison, (517) 337-1351.

October

4, MSMS/PSG Health Law Update, Amway Grand, Grand Rapids, Michigan Contact: Amy Fistler, (517) 337-1351. Ext. 65.

5, MSMS/PSG Fostering Positive Physician-/Patient Relations, Weber Inn, Ann Arbor, Michigan. Contact: Amy Fistler, (517) 337-1351. Ext. 65.

11,12, MSMS/PSG Third Party Reimbursement and Coding, 11th – Amway Grand, Grand Rapids, Michigan. 12th – Somerset Inn, Troy, Michigan. Contact: Amy Fistler, (517) 337-1351. Ext. 65

18,19, MSMS/PSG Retirement Planning, 18th – Hyatt Regency, Dearborn, Michigan. 19th – Amway Grand, Grand Rapids, Michigan. Contact: Amy Fistler, (517) 337-1351. Ext. 65

25, MSMS/PSG Starting Yourself in Medical Practice, Dearborn Inn, Dearborn, Michigan. Contact: Amy Fistler, (517) 337-1351. Ext. 65.

November

7-9, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn. Contact: Sherry Fent, Chief of Physician Education, (517) 337-1351.

AMA Meetings

October

2-3, Eighth Annual AMA Science Reporters Conference, Marriott Medical Center Hotel, Houston, Texas, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610. (312) 645-4417.

Michigan Specialty Society Meetings

September

19-21, The Annual Northern Michigan Seminar: Respiratory Care 1989. Contact: MSRC, P. O. Box 950, East Lansing, MIchigan 48826-0950.

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633.

National Specialty Society Meetings

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601. (312) 644-6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091. (703) 648-8900.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911. (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact: American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114. (816) 333-9700.

21-23, American College of Nuclear Medicine Scientific Meeting, Swiss Grand, Chicago, IL. Contact: American College of Nuclear Medicine, Box 5887, Columbus, GA 31906. (404) 322-8049.

21-24, American College of Nuclear Physicians Interim Meeting, Loews L'Enfant Plaza Hotel, Washington, DC. Contact: American College of Nuclear Physicians, 1101 Connecticut Ave., NW, Ste. 700, Washington, DC 20036. (202) 857-1135.

24-27, American Neurological Association, New Orleans, Contact: American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414. (612) 378-3290.

24-28, American Academy of Otolaryngology – Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology – Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005. (202) 239-4607.

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016. (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068. (312) 825-5586.

14-19, American Psychiatric Association, Interim Meeting, Adam's Mark, Philadelphia, PA. Contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005. (202) 682-6000.

Other Meetings

September

11-13, Treatment of Destructive Behaviors in Persons with Developmental Disabilities, Warren Grant Magnuson Clinical Center, Bethesda, Maryland; Rockville Pike, Rockville, Maryland 20852. (301) 468-6555.

22, Prevention and Rehabilitation of Stroke, Sunnybrook Medical Centre, University of Toronto. Contact: Organizing Secretary – (416) 480-4287.

22, Michigan Medical Group Management Association, McGuire's Resort Center, Cadillac, Michigan. Contact: Caroline Kimmel, MSMS, 1305 Abbott Rd., P. O. Box 950, Lansing, MI 48826-0950. (517) 337-1351.

October

20, Multiple Sclerosis-1989 Conference. Contact: David Irwin, Hospitals Communications, (614) 459-3909.

November

8, Michigan Board of Vocational Experts, Fourth Bi-Annual Conference. Contact: Dr. John Caknipe, (313) 326-4280, or Ann Tremblay.

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Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

September

11-12, Epilepsy Advances. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

11-16, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School; Michigan Association of Pediatric Directors; Michigan Chapter; American Academy of Pediatrics. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Unviersity of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 936-9800. **Approved for:** 55 hours Category I Credit.

13, Update: Medical Management & Treatment of Arthridities. Location: Southfield Hotel & Conference Center. **Contact:** Shelley L. Helton, CME/Program Assistant, Henry Ford Hospital, Office of Medical Education, 2799 W. Grand Blvd., Detroit, Michigan 48202-2689. (313) 87630373. **Approved for:** 4 hours Category I Credit.

14-16, Recent Trends in Clinical Electrophysiology: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Unversity of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

15-16, Recent Trends in Electrophysiologic Assessment: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

21-23, The National Conference on Pediatric Trauma. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** Kiqanis Pediatric Trauma Institute, New England Medical Center, University of Michigan Medical School, General Motors Corp. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763- 1400. **Approved for:** 20 hours Category I Credit.

21-24, 34th Annual ACP-Michigan Chapter/MSIM Regional Meeting. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** American College of Physicians, Michigan Chapter and the Michigan Society of Internal Medicine. **Contact:** Patrick C. Alguire, MD, FACP, Department of Medicine, Michigan State University, B-301 Clinical Center, East Lansing, MI 48824. (517) 353-5100. **Approved for:** 18.5 hours Category I Credit.

28-30, Advanced Concepts in Total Hip & Total Knee Revision Surgery. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, CME/Program Assistant, Office of Medical Education, 2799 W. Grand Blvd., Detroit, Michigan 48202-2689. (313) 876-3073. **Approved for:** 16 hours Category I Credit.

October

2-3, Update on Pulmonary and Critical Care Medicine. Location: Towlsey Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

4-6, A Symposium on Neonatal Respiratory Disorders. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

5-7, 12th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

12-13, Office Procedures for Primary Care Physicians. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

12-14, 20th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids, Michigan. **Sponsors:** MSU College of Human Medicine, International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Bldg., 1900 Wealthy S.E., Suite #290, Grand Rapids, MI 49506. (616) 774-0440. **Approved for:** 18 hours Category I Credit.

18, Pediatric Urology for the Practitioner. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 10 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial and Behavioral Issues. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medial School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. **Approved for:** 13 hours Category I Credit.

20-21, Psychiatry Update 1989 - A Tribute to Raymond W. Waggoner, MD. Location: The Michigan Inn, Southfield, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing

(Continued on page 64)

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25-28, Midwest Addictions Conference. Location: Detroit Radisson Hotel, Detroit Airport. **Sponsors:** Samaritan Health Center; American Medical Society on Alcoholism and Other Drug Dependencies; Western Michigan Addictionology Consultants, Inc.; and Michigan Psychological Association. **Contact:** Diane Campbell, Samaritan Health Center, 5555 Conner Ave., Detroit, MI 48213. (313) 579-4925. **Approved for:** 26 hours Category I Credit.

26-27, Critical Care Issues in the Care of the Elderly. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Geriatric Medicine, Department of Internal Medicine VAMC. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

November

2-4, Modern Perinatal Problems: An Update for the Practicing Obstetrician-Gynecologist. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-11, 37th Annual Detroit Trauma Symposium, Harper Hospital, Detroit. Contact: Marjorie Norum, Dept. of Surgery, Harper Hospital, 3990 John R, Detroit, MI 48201. (313) 745-2345.

13-14, 8th Annual Michigan Statewide Conference on Child Abuse and Neglect; Child Abuse and Substance Abuse. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, University of Michigan Child Protection Team. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

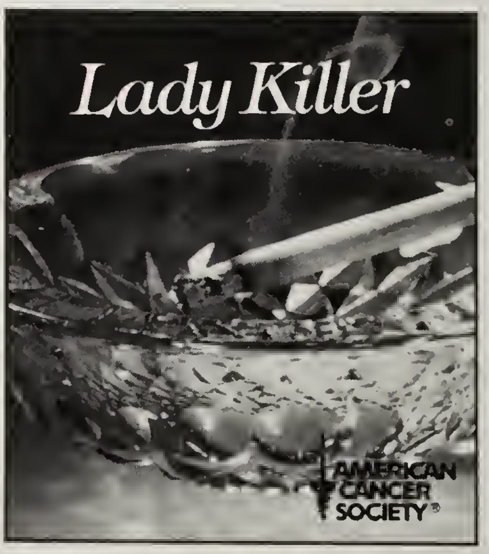
18, Every Doc's Pediatric Dermatology. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Department of Dermatology. **Contact:** Diane Davis, Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202. (313) 876-3073 or 800-888-4340. **Approved for:** 4.5 Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial & Behavioral Issues. Location: Towsley Center, Ann Arbor Michigan. **Sponsors:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, Michigan Affiliate - American Diabetes Association. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

29-30, Second Annual Symposium on the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Dpartment of Anesthesiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

December

4-6, Emergency Medicine: Orthopedics. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 17 hours Category I Credit.



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PRESIDENT'S PAGE

Abortion — MSMS Has Many Concerns

By Robert E. Paxton, MD

Thucydides in 400 B.C. writing about an Athenian war stated, "...the bravest are surely those who have the clearest vision of what is before them, glory and danger alike, and yet not withstanding go out to meet it."

I can't foresee any glory in discussing abortion; I am sticking my neck way out. I can only join with Ibsen and declare, "Oh courage...If only I had that then life might be livable in spite of everything!"

Frankly, I'm not excited writing about the abortion issue. But it has become necessary for us to be heard on the subject. The July decision of the U.S. Supreme Court allows states to restrict abortion rights, taking the issue out of the courts and putting it squarely in the local political arena.

This has created a divisive turmoil in this nation which continues to reverberate from coast to coast and will only grow in intensity. Some declare that it is unconscionable to take away an individual's right to choose and place it in the hands of legislators. Others say the people, through representatives, have the right to stop the killing of the unborn — a responsibility inherent in the state.

The debate is intense. The convictions run deep. Medicine itself is not void of the controversy. In the July 17 issue of *Newsweek*, it states that doctors are just as divided on abortion as the rest of the American public. It's just that they don't yell and scream at each other.

Personally, I do not believe in abortion. I would consider it wrong for me to perform one. On the other hand, I will support the right of free choice to those who think otherwise until more convincing evidence is apparent. In my role as MSMS president, however, I stand ready to represent the views of the Society.

All summer the press has requested an opinion on how Michigan doctors feel about the issue. I hope this will help to set the record straight. Afterall, physicians are the ones directly involved in the abortion process.

The official stand of the Society was reached by a democratic process and was confirmed in 1986 by a statistically significant survey done by Martin Block, PhD, of Northwestern University. There have been no indications of change since that time.

Our official policy is comprised of six distinct stands on the subject of abortion. (See chart below.)

This is the official policy. But what is the deep concern of MSMS and Michigan physicians? It is the adverse effect of the abortion dilemma on other important issues.

Dangerous spillovers from this debate are overt legal attempts to curtail sex education, birth control information and services to teenagers as well as opposition to right to die legislation. The rhetorical condemnation of these activities by certain right to life groups is disturbing.

As a medical society, we have no desire to undermine the authority of the home. To the contrary, it is in the best interests of medicine to strengthen it. However, we must realistically face the problem and do our best to prevent unwanted pregnancies with proper education and birth control services.

Another responsibility assumed by the medical society is adequate prenatal care and well baby follow-up for the poor — a concern that should be shared by all of Society. We would implore anti-abortionists activists to join us as we seek means of access into the health care system of this underserved and often neglected group of patients.

Consistent with my goals as president, I urge my colleagues to remain unified. Do not let this, nor any other issue, divide us. Utilize debate and the democratic process to further your own ideas and concepts, but in the end remain committed to organized medicine for the betterment of our patients and our profession. ■

Doctor Paxton is MSMS president.

The Society's Official Stand on Abortion

	Agree	Disagree
1. We do not believe in a constitutional amendment banning abortion.	76.5%	23.5%
2. The MDPH guidelines for voluntary abortions are properly quality control criteria. DSS and insurance companies should provide adequate coverage.	63.9%	36.1%
3. We support medicaid funded abortions.	61.9%	38.1%
4. Abortion is a medical procedure and as such must conform to quality control standards of care.	95.3%	3.7%
5. Medical personnel, including physicians and hospitals, should not be forced to be a part of an abortion if it violates their moral judgment.	98.2%	0.8%
6. Patients must not be coerced into decisions regarding abortion or sterilization.	90.3%	9.7%

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MICHIGAN MEDICINE

Award-Winning Journal of the Michigan State Medical Society

OCTOBER 1989
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Cover Story

"Spectrum of Medicine" is the theme of this year's Annual Scientific Meeting, scheduled for November 7-9 at the Hyatt Regency Hotel in Dearborn. The spectrum is key to the 1989 ASM as it symbolizes today's wide-ranging challenges to the Michigan physician, and hence the broad scope of topics covered. This year's ASM will feature courses which take an encompassing view — tackling medical issues which cut across all specialties and affect all patients. Hepatitis B, drug abuse, weight loss, violence in families, the environment, childhood depression, and AIDS are some of the broad spectrum of topics which will be addressed at the meeting. To help make this year's ASM the best ever, Michigan Medicine is featuring 19 pages of information on the event, from course listings to exhibitor information. We hope attendees will find this "convention special" useful.

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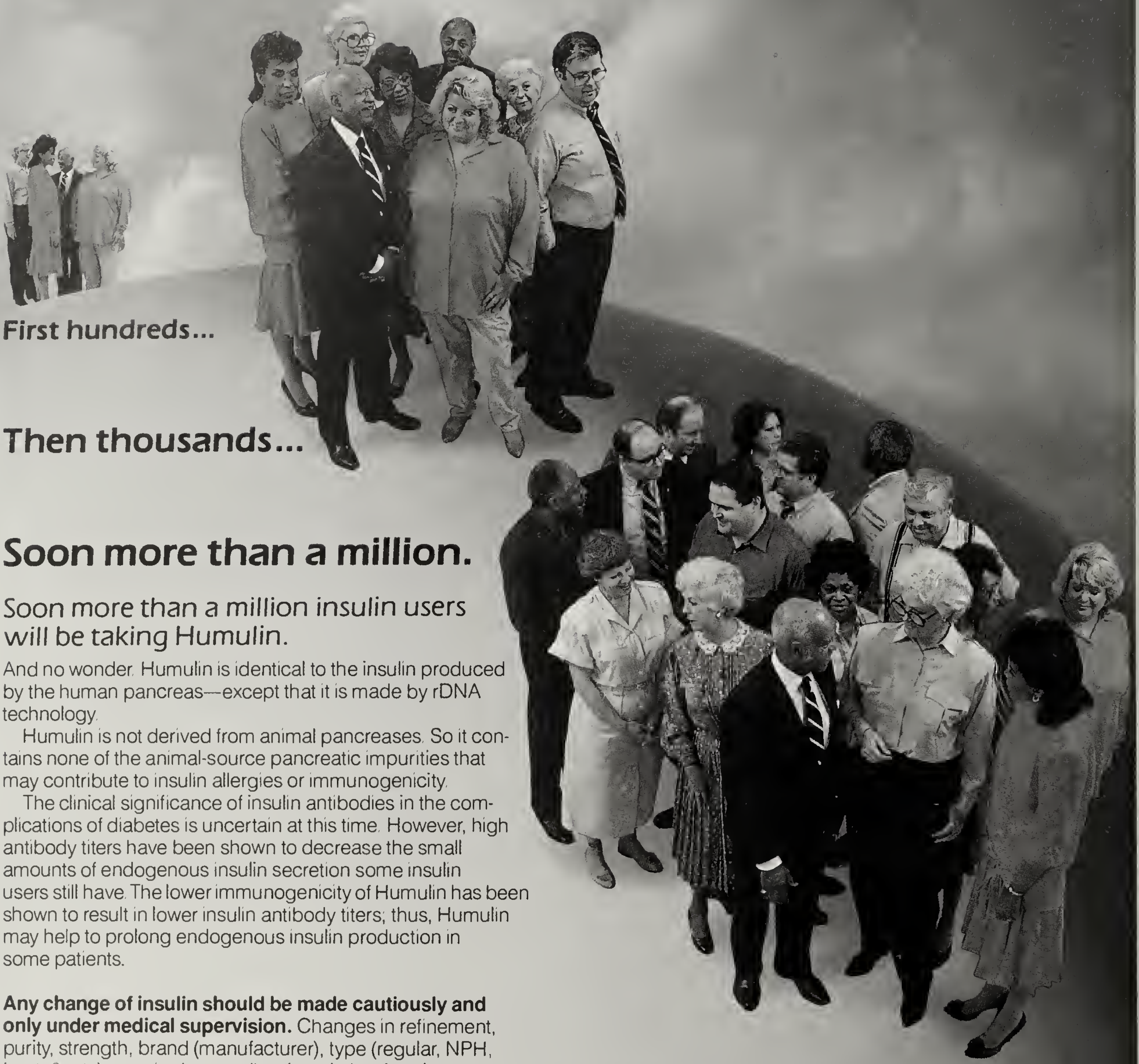
Cover illustration by: Hudson Creative Group



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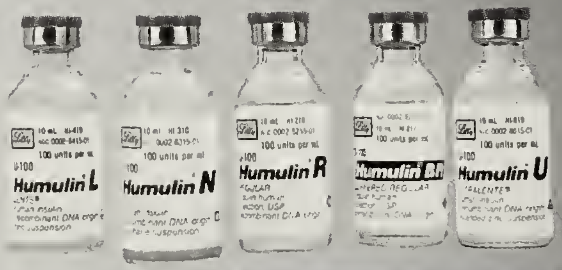

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The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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IN MY OPINION

Annual Scientific Meeting an Important Event

By Henry M. Domzalski, MD

Labor Day signaled the end of summer — the end of vacation and playtime — and a return to our usual pattern of life.

This past summer I had the opportunity to spend many pleasant days in various spots of the state. This experience reinforced long-held feelings that we are privileged, indeed, to live and work in this great state of Michigan.

Despite the frustrations we encounter and attempt to overcome each day, Michigan truly is a wonderful place to be — with its incomparable natural beauty, spectacular scenery, season changes to enjoy, and for the most part, the company of industrious and friendly people.

We also are privileged to have world-renowned academic excellence, with three outstanding medical schools within our borders. We have a vast pool of talented practicing physicians. This excellence offers each of us — each year — the opportunity to update, rather painlessly, our knowledge and skills.

The MSMS Annual Scientific Meeting (slated for November 7-9) will be upon us soon. Needless to say, it is a very important event for Michigan physicians.

The ASM Planning Committee, under the able chairmanship of Joan Stryker, MD, has assembled an outstanding program which covers a spectrum of medical challenges. As Doctor Stryker has said, the spectrum is key to the 1989 MSMS Annual Scientific Meeting as it symbolizes today's wide-ranging challenges to the Michigan physician, and hence the broad scope of topics offered.

This year's ASM will feature courses which take an encompassing view — tackling medical issues which cut across all specialties and affect all patients. Courses will address diseases and conditions which pose a threat to the health of our nation, and which provide opportunities for physicians to take a large role in affecting all of society. Hepatitis B, drug abuse, weight loss, violence in families, the environment, childhood depression, and AIDS are some of the broad spectrum topics which will be addressed at the meeting.

With only a little effort on your part, you can avail yourself of this fine program and the featured experts. At the same time you can renew old acquaintances, and perhaps make new ones. I hope to see you there. ■

Doctor Domzalski is a member of the MSMS Board of Directors and is chairman of the MSMS Committee on Publications.

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Letters from Our Readers

Newly-formed group supports woman's right to safe, legal abortion

A national organization of physicians who support a woman's right to choose safe and legal abortion is currently being formed.

Called Physicians for Reproductive Health, the organization's members will provide education to the general public on the medical facts of reproductive health issues. These include: the important role legal abortion plays in insuring and protecting women's physical and mental health; the need for better access to contraceptive methods that are currently available and undergoing research and development.

Physicians for Reproductive Health is creating both a Speakers' Bureau of physicians willing to discuss the issues with the media and community groups and a Writers' Bureau.

Kevin Weiss, MD, executive vice president of PRH, said, "I urge physicians of every specialty to join PRH, even those who are not involved in reproductive health issues. The government is currently seeking to interfere in the way we treat and counsel patients. All physicians must act together to prevent this intrusion."

In addition to the national membership, PRH is currently forming local chapters. Membership is open to all physicians and medical students.

For more information on Physicians for Reproductive Health, please contact Doctor Kevin Weiss or Tamar Abrams, Suite 147, 2020 Pennsylvania Avenue, NW, Washington, DC 20006.

Tamar Abrams
Physicians for
Reproductive Health
Washington, DC

Michigan Association targets private rehabilitation practitioners

The Michigan Chapter of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) has been created to provide educational, legislative and professional information to private rehabilitation practitioners and other parties interested in helping the disabled persons with medical and vocational case management review.

To join the group, or for more information, contact: Craig Timmer, western region representative, at (616) 784-5555; or Katie Goodwin, eastern region representative, at (313) 851-0700.

Katie Goodwin
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Public Relations Committee
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Drug offers hope for premature infants with breathing disorder

An experimental drug being tested at the University of Michigan Medical Center and other hospitals throughout the United States and Canada has been shown to reduce by up to 40 percent the number of infant deaths from Respiratory Distress Syndrome (RDS), the most common cause of death and disability among premature babies.

Perhaps the most well-known infant to die from RDS was a boy born in 1963 to former President John F. Kennedy and his wife, Jacqueline.

RDS is caused by the inability of underdeveloped lungs to manufacture a slippery, film-like substance called surfactant, which aids and maintains lung inflation and prevents the airways from collapsing.

The new drug, called Exosurf Pediatric, is a synthetic version of the body's natural lung lubricant. It comes in a sterile, freeze-dried powder that is reconstituted at bedside with sterile water. The resulting white, soapy liquid is then administered directly into the infant's lungs.

Without surfactant, infants are unable to breathe properly and do not take in enough oxygen or have the ability to remove carbon dioxide from their lungs.

"For these babies, taking a breath is like trying to blow up a balloon for the first time. It's quite difficult for them," said Robert E. Schumacher, MD, an assistant professor of pediatrics and communicable diseases who heads the artificial surfactant study at the U-M Medical Center.

The U-M trials, which began in June 1988, are funded by a $250,000 grant from Burroughs Wellcome Co., the developer and manufacturer of the drug.

The first three phases of the U-M study, now complete, targeted infants of varying birth weights. Studies involving single and multiple dosages in infants under 2.5 pounds are ongoing. In a follow-up study, Doctor Schumacher and his colleagues will chart the progress of infants who were treated in the first three protocols to understand the long-term effects of surfactant therapy.

The multicenter double-blind trials, which began in 1986, have involved 50 hospitals and approximately 3,000 premature infants ranging in size from 1.5 pounds to 2.5 pounds at birth. The trials compared Exosurf Pediatric used in conjunction with conventional treatment (oxygen and ventilation) to conventional treatment alone.

Conventional treatment for RDS involves placing infants on ventilators that force high concentrations of oxygen into the lungs. The combination of high ventilator pressure and high oxygen concentrations can themselves damage and scar the lungs, Doctor Schumacher said. Other side effects from long-term ventilator support include brain hemorrhaging, blindness, retardation, and cerebral palsy.

Successful treatment with artificial surfactant can allow earlier weaning from the ventilator, which decreases the chances of such complications.

Based on the results of the multicenter trials, the US Food and Drug Administration (FDA) in late July agreed to make Exosurf Pediatric available to critically ill infants for whom no satisfactory alternative treatment exists. About 600 approved centers nationwide are expected to receive the drug free of charge before it receives final marketing approval. Exosurf is one of only 13 drugs that have been authorized for early release by the FDA.

New system may offer patients a reprieve from kidney dialysis

Researchers at Henry Ford Hospital announced in August their success with a new procedure under clinical investigation which may make it possible for many more patients suffering from kidney failure to receive a kidney transplant.

Henry Ford Hospital physicians reported on a new blood filtering system, under development by the E.I. Du Pont Company, that may remove a major obstacle to transplant surgery for some patients who need a donor kidney. Called extracorporeal immunoadsorption, the treatment is intended to reduce abnormally high levels of antibodies in the bloodstream of these patients. The hope is that this will reduce the chance of rejecting the transplanted organ by the patient's immune system.

"This treatment may open up access to organ transplantation for patients who would otherwise stay on the waiting list for a transplant interminably," says Warren L. Kupin, MD, a Henry Ford Hospital nephrologist.

In collaboration with the E.I. Du Pont Company, teams of researchers are conducting clinical trials with the system at several prominent centers in Europe and in the US in order to obtain Food and Drug Administration approval for the system.

The treatment was used for the first time in this country to transplant a kidney into a Michigan patient. The recipient, Darlene Wilson, 36, of West Bloomfield, who had been dependent on dialysis for eight years, is doing very well with the kidney transplant she received May 15 at Henry Ford Hospital.

Because antibodies defend the body against any substances that are perceived as "foreign," such as a transplanted organ, an overabundance of antibodies means almost certain failure for any transplant attempt unless the transplanted organ is perfectly matched to the patient's immune system. This excess production of antibodies in some patients with kidney disease usually is caused by pregnancy, blood transfusions, previous transplant attempts or viral infections.

"These patients' bodies have built up such a strong immune response and have become so sensitized to foreign tissue that they would reject any kidney immediately if it was given to them," according to Steve Malcom, administrative manager of Greenfield Health

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Systems Corporation, a subsidiary of Henry Ford Health Care Corporation whose services include kidney dialysis. "The antibody levels in these patients are much too high to be treated with conventional immunosuppressant agents. To have any effect on antibodies, the dosage would be so large it would be toxic to the patient."

To reduce the level of antibodies in the blood before transplantation is attempted, patients undergo treatment similar to dialysis. Blood is pumped through a centrifuge to separate the plasma from blood cells. The plasma then travels to a second instrument of the system, the Du Pont Antibody Removal System, which is designed to remove IgG antibodies from it. After this treatment, the plasma rejoins the blood cells and the blood is then circulated back into the patient. Each treatment takes about four hours. Throughout the procedure — which is well tolerated — the patient remains comfortably seated in a reclining chair.

Treatments must be repeated until the level of antibodies circulating in the blood has fallen to a more manageable level. To achieve that, the patient usually must undergo three to five separate treatments.

As soon as the antibodies have reached a more normal level, the patient is eligible for a transplant.

Sinai Hospital offers help for prostate problems

Enlargement of the prostate gland, a common problem in men over 50, traditionally has been treated with fairly major surgery. Thanks to a new outpatient procedure pioneered by Michael Lutz, MD, Sinai Hospital of Detroit urologist, there may be an alternative to the more complicated surgery for many patients.

Sinai is one of 15 hospitals nationwide participating in clinical trials on the year-old procedure — balloon dilation of the prostate. Doctor Lutz, who became the first physician in Michigan to do this procedure, has treated 35 patients since July 1988.

Fifty percent of all men over 50 suffer from benign prostate hypertrophy, or enlargement of the prostate gland. Symptoms include difficulty in urinating, a decreased stream, and an inability to empty the bladder. More advanced cases of urinary outlet obstruction can lead to urinary tract infections and even kidney failure. The surgical approach to alleviating the problem is transurethral resection of the prostate, which removes, piece by piece, the tissue blocking the prostate urethra.

Doctor Lutz and the other urologists participating in the clinical trials believe the new balloon dilation technique appears to be a viable option for many men with benign prostate hypertrophy.

"The procedure involves visualizing the opening of the prostate channel and calibrating the size of the prostate," explains Doctor Lutz. "A catheter with a small balloon at its tip is inserted into the urethra and the balloon is inflated to three atmospheres pressure, which is maintained for 10 minutes. The balloon stretches and enlarges the prostatic urethra."

The real attraction of the balloon dilation procedure is that it carries minimal risks, according to Doctor Lutz. It can be performed with local anesthetic and sedation. The patient spends two hours for observation in the recovery room before returning home with a catheter, which is removed 24 to 48 hours later. If the dilation procedure is not successful, the patient is still a candidate for the transurethral resection of the prostate.

"There are half a million transurethral resections performed annually in the United States," says Doctor Lutz. "More than 250,000 of them are potential candidates for balloon dilation."

Physicians in the News

Evelyn J. Fisher, MD, is the newest recipient of the Mercy Medallion, given by the Mercy College of Detroit. This medallion is given in honor of lives and activities which are examples of traditional or contemporary works of mercy. Doctor Fisher is an infectious disease specialist and strives to solve the problems associated with AIDS. She co-founded Wellness Networks, Inc., a support group aimed at dealing with the medical and social aspects of AIDS. She has held information and prevention seminars, lobbied for research funding, helped establish confidential blood testing sites, and has served on the AIDS Task Force for Provider Education in Michigan.

Ian Jackson, MD, medical director of the Institute for Craniofacial and Reconstructive Surgery, contributed several medical papers at the Second Congress of the International Society of Cranio-Maxillo-Facial Surgery, held recently in Florence, Italy. Doctor Jackson also provided insights to new surgical techniques which ensure greater safety and reduce complications. Earlier this year he joined the Institute as a medical director/surgeon/principal consultant. Doctor Jackson is a founding member of the International Society of Cranio-Maxillo-Facial Surgery and is a member of several other national and foreign medical societies.

Robin C. Buerki, MD, is the most recent addition to the Health Care Hall of Fame. Doctor Buerki retired from Henry Ford Hospital in 1964 at the age of 71. He has served as the president of the American Hospital Association and the chairman of its Council on Professional Practice; vice president in charge of medical affairs at the University of Pennsylvania, dean of the Graduate School of Medicine, and director of the University's hospitals. Doctor Buerki was also instrumental in the beginning of the Henry Ford Hospital Medical Bulletin and the "Big Six" clinic group.

John C. (Kevin) Sullivan, MD, is the newly-appointed vice president, Medical Affairs, Port Huron Hospital. He received his medical degree from Wayne State University and has been practicing otolaryngology in Port Huron since 1972. Doctor Sullivan has also served as the medical director for Port Huron Hospital since 1986. He is certified by the American Board of Otolaryngology and has been a member of the American Academy of Physician Executives since 1985.

Henry Ford one of six centers to study effects of AIDS on lungs

Henry Ford Hospital is one of only six medical centers in the United States recruiting AIDS-infected individuals for a study examining the effects of the AIDS virus on the lungs. The study is funded through the National Institutes of Health.

"The more we learn about the effect of the AIDS virus on the respiratory system the better physicians will be able to diagnose, treat, and prevent the lung complications so common in this syndrome," said Paul Kvale, MD, the study's principal investigator and staff physician in the Division of Pulmonary Medicine.

"To date, 1,169 people in Michigan have developed AIDS and 673 of these people have died," said Louis D. Saravolatz, MD, co-principal investigator for the study. "And there are an additional 4,400 people who currently are infected with the virus and don't even know it.

"It's going to take a combination of education about prevention and medical breakthroughs in treatment to stop this deadly disease," Doctor Saravolatz added. "Our research efforts can be successful only if the public, especially those already infected with the virus, come forward and help."

The purpose of the $2 million, four-year Pulmonary Assessment Clinical Study (PACS) is to identify the types, incidences and causes of the pulmonary disorders affecting individuals infected with the AIDS virus. Researchers also hope to determine if early detection of these pulmonary disorders — using screening tests — improves the treatment outcome for persons with AIDS disease.

"About 80 percent of all patients with AIDS acquire pneumocystis carinii pneumonia (a rare form of pneumonia) and about 30 percent of those patients have had multiple bouts during the course of the illness," Doctor Kvale said.

"While we have some knowledge of pneumocystis, there are many basic questions as yet unanswered," Doctor Kvale added. It is unknown, for example, if the AIDS virus itself produces pulmonary disease, or just weakens the immune system, permitting other infections to damage the lungs.

"We need to find out more about the causes if we want to better treat the conditions."

The Henry Ford Hospital study will look at the effects of the AIDS virus on the lungs of 200 men and women infected with the AIDS virus, but who have not developed full-blown AIDS. Participants must be 18 years or older.

The three patient study groups include:

- Women who acquired the virus through sexual activity.
- Men and women who acquired the virus through the sharing of intravenous drug needles.
- Gay and bisexual men who acquired the virus through sexual activity.

Researchers are currently recruiting women and intravenous drug users for the study.

"The greatest difficulty has been in finding women and IV drug users to participate in the study," said Joanne Huitsing, RN, project coordinator for the study. "They are less likely to seek help or support fearing discrimination by society and alienation by their friends and family."

Participation in the study is confidential. Free, complete lung function tests and physical examinations are provided to participants who qualify for the study. Participants' lung functions and general physical conditions are assessed every three to six months during the study.

"Because the study's participants are followed so closely, complications of the AIDS infection may be identified early on, potentially improving treatment success," Doctor Kvale explained. Also, any experimental treatments that come available through the hospital, will be made available to PACS participants who qualify.

Insured patients will be treated for symptomatic conditions of the AIDS virus infection by Henry Ford Hospital specialists — leaders in the state in the diagnosis and treatment of AIDS. The Henry Ford staff also can assist AIDS-infected individuals in finding the health, financial and support services they need.

Other medical centers participating in the study include the University of San Francisco, the University of California in Los Angeles, Northwestern University in Chicago, the Medical College of New Jersey and Mount Sinai Hospital in New York.

For more information, call PACS at (313) 876-2666.

Sixteen hospitals, health care groups honored for child care programs

Sixteen Michigan hospitals and health care organizations were among more than 100 businesses recognized in August by the "Michigan Child Care Challenge" for their efforts to provide employer-supported child care options.

Three hospitals received special recognition for their outstanding achievements in child care benefits.

The House Republican Task Force on Child Care, chaired by State Representative Lyn Bankes (R-Livonia), designed the Michigan Child Care Challenge to highlight employers who have responded to their employees' child care needs. Participants were honored at press conferences in Livonia and Grand Rapids.

"By highlighting the positive employer-sponsored child care programs already in existence, we encourage other companies to offer child care as a benefit," Representative Bankes said.

"Business does not welcome government-mandated benefits, and the task force agrees. Organizations need to know the advantages of providing child care options to their employees voluntarily. Absenteeism drops dramatically, employee morale is boosted and productivity increases for businesses that offer this benefit."

The child care task force was established in 1987 by the House Republican Policy Committee. In 1988, the task force released the "Michigan Employers' Guide to Child Care," a "how-to" manual for businesses that are interested in providing employer-sponsored child care. More than 8,000 requests for the report have been received, and the success of the guidebook led to the creation of the Michigan Child Care Challenge.

There were several award categories in which businesses were nominated. Outstanding achievers in these areas include Oakwood Hospital Child Care Center (Dearborn) and Bronson Healthcare Group (Kalamazoo) for "Best on the Block" — companies that have made special efforts to design child care programs that are unique; and Sparrow Hospital (Lansing) for "New Kid on the Block" — companies most recently offering child care benefits.

All nominees received certificates recognizing their leadership in employer-supported child care. Other hospitals and health care organizations recognized include:

- Blodgett Memorial Medical Center (Grand Rapids), Chelsea Community Hospital, Oakland General Hospital (Madison Heights), Hackley Hospital (Muskegon), St. Joseph Health Network (Mount Clemens), for "Best on the Block."
- Botsford General Hospital (Farmington Hills), for "Innovator" — organizations that have demonstrated extra effort in providing solutions to the child care dilemma.
- Blue Cross/Blue Shield of Michigan (Detroit), Henry Ford Hospital (Detroit), Mount Carmel Mercy Hospital

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(Detroit), Northern Michigan Hospitals Inc. (Petoskey) and Pontiac Osteopathic Hospital for "Helping Hands" — businesses that offer direct financial assistance to their employees or subsidize on-site centers.

- Ingham Medical Child Development Center (Lansing), for "Grandparent" — companies that have been pioneers in offering employee child care benefits.
- North Ottawa Community Hospital (Grand Haven), for "New Kid on the Block."

MHCC provides health care to needy Wayne County residents

The Michigan Health Care Corporation, through its Master Care Plan (MCP), has provided fixed-rate health care to thousands of needy Wayne County residents since October 1988.

Under a one-year, renewable contract, MHCC furnishes medical care — preventative treatment, outpatient care and acute inpatient care — to about 14,000 General Assistance (GA) recipients.

Believed to be the largest of its type in the nation, this program is managed similarly to a health maintenance organization (HMO).

Under the program, 50,000 county enrollees have membership cards and are assigned a primary care provider. Covering both hospitalization and outpatient care, medical benefits are similar to the state Medicaid program. Depending on where they live, members are assigned to one of four providers of medical care.

The plan was authorized by the state legislature because the county's cost of providing health care to this segment had jumped from $3 million in 1970 to $32.5 million in 1988. Under the old system, hospitals provided treatment and billed the state, which in turn billed the county. The county was unable to control costs, officials said, because it was not involved until after the costs had been incurred.

In fiscal year 1987-1988, the county and the state together paid a total of $75 million for indigent medical care. Under the new program, that cost will be cut to $58 million with the county's obligation down by more than half — from $32 million to $15.5 million. The state's share remains the same at $42.5 million.

MHCC is paid approximately $73 a month for each patient regardless of the total medical expenses. Like an HMO, MHCC only profits if the total medical costs do not exceed the $73-a-month flat fee for each patient. (Medicaid pays about $83 a month for each patient.)

The Master Care Plan involves several MHCC divisions, including Park Medical Center and Michigan Health Center's Medical/Surgical facility.

During the first three months, Park Medical Center had more than 10,000 ambulatory visits from Plan members, while Michigan Health Center provided more than 1,600 days of care. The program brought $7.7 million in revenues from the County.

1990 hospital standards manual available from JCAHO

The 1990 edition of the *Accreditation Manual for Hospitals* (AMH) is now available from the Joint Commission on Accreditation of Healthcare Organizations. The 1990 AMH contains new and revised standards for patient complaint management, infection control, ambulatory care, and other services. It also explains the procedures that apply to conditional accreditation, the Joint Commission's new accreditation category.

The 1990 *Accreditation Manual for Hospitals* costs $90. To order, contact the Joint Commission's customer service unit at (312) 649-8108.

Michigan State Medical Society

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SPECTRUM OF MEDICINE

1989 MSMS ANNUAL
SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

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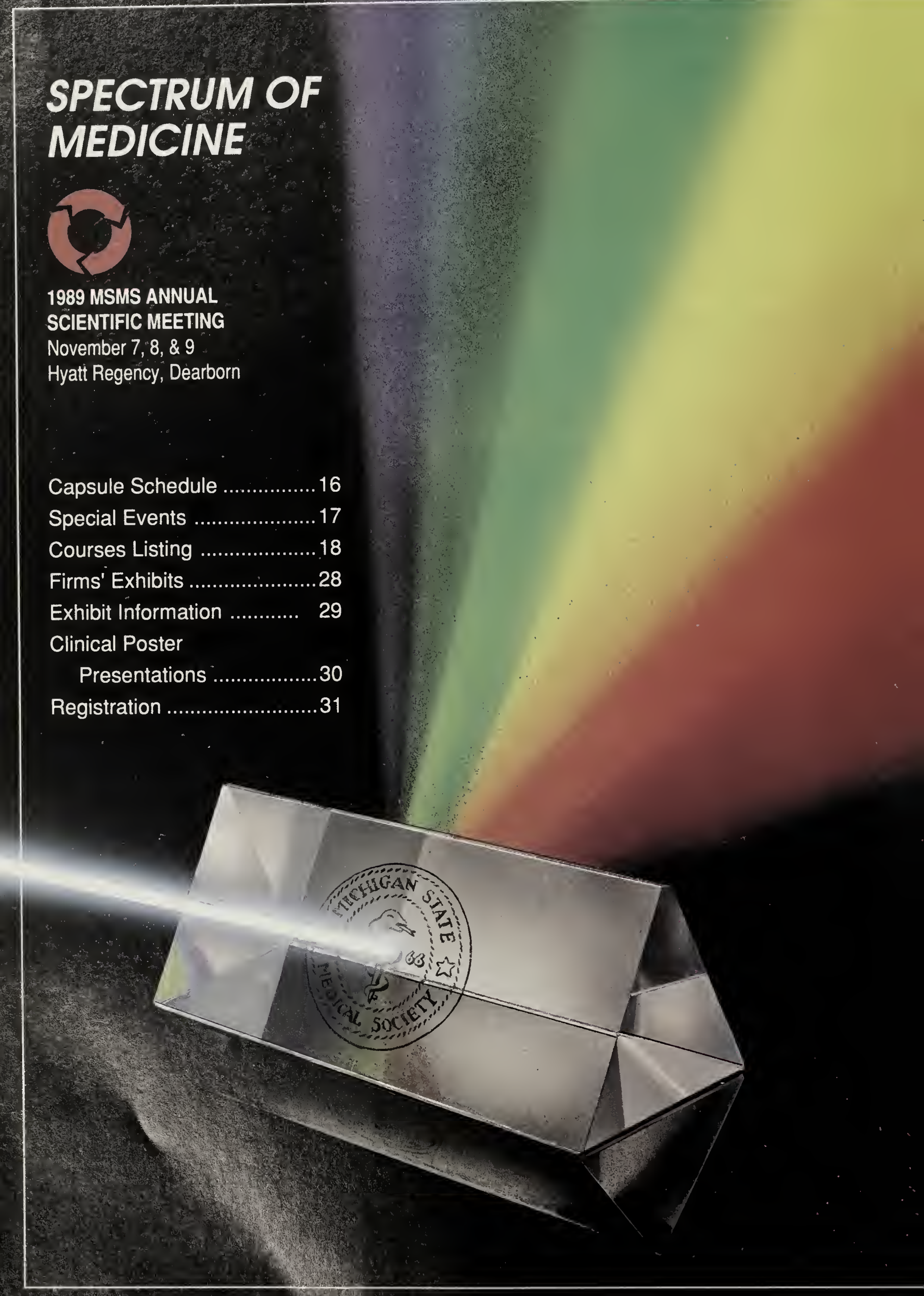
MICHIGAN STATE MEDICAL SOCIETY
66

Spectrum of Medicine
1989 Annual Scientific Meeting

By Robert E. Paxton, MD
MSMS President

Robert E. Paxton, MD

Throughout its history, MSMS has had a variety of purposes which reflect the needs of any given era. Characteristically, medicine is dynamic and changes occur just as they do any place else in society. We have seen this dramatically demonstrated in the health care delivery system for the past twenty-five years. Such changes have resulted in a shift in MSMS emphasis so that considerable resources have been diverted towards the socioeconomic aspects of medicine. We are rightfully concerned about the malpractice crisis, the plight of the uninsured, limitations of medicare benefits and threats of a monolithic national health insurance program.

Despite this pressure of an ever-changing world, there is one area that has remained constant and never changes. It is the consistent interest of MSMS in quality medical care and the continuing medical education of its members. This priority has not changed since the early beginnings of our organization; competency of Michigan physicians remains foremost. Once again we see this concern demonstrated by the Annual Scientific Meeting.

Although educational and scientific activity are predominate forces of the specialty societies, the MSMS Annual Scientific Meeting offers a unique update on a variety of disciplines that can hold the interests of all physicians. I can assure you, this particular type of program with its continuing success is the envy of many state medical societies.

So I invite you to a stimulating session next month that not only is innovative in its presentation but also offers up-to-date, practical medical knowledge. I make a special appeal to my colleagues in the west and northern part of the state. For over ten years I have been complaining that the ASM has always fallen on the opening of deer season! Finally someone has listened and the deer hunters can make it this year. Plan to attend — you won't be sorry.

Capsule Schedule of Annual Scientific Meeting

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

TUESDAY, NOVEMBER 7

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Concurrent Scientific Courses *(run until Noon)*
- Depressive Disorders
- Basic Cardiac Life Support
- Congestive Heart Failure
- Critical Care
- Magnetic Resonance Imaging
- Industry & The Environment
- Pain Control for Terminal Cancer
- Ear Problems
- New Arthritides

Clinical Poster Display *(all day)*

12 Noon
Luncheon for All Registrants

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*
- Breast Cancer
- High Risk Patient
- Childhood Depression
- Gastrointestinal Surgery
- Physician-Patient Relationships
- Orthopaedics in Family Practice
- Perioperative Risk Management
- Safe Weight Loss
- Eye and Systemic Disease
- Ethics

6:00 PM
Reception
MSMS ASM Planning Committee

WEDNESDAY, NOVEMBER 8

7:00 AM
"Early Bird" Plenary Session on Drug Abuse
Hubbard Ballroom *(Coffee & Rolls included)*

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Clinical Poster Display *(all day)*
Concurrent Scientific Courses *(run until Noon)*
- Antimicrobial Therapy
- Basic Cardiac Life Support
- Poisonings and Overdoses
- Hypercholesterolemia
- New Reproductive Technologies
- Primary Care for Women
- Adolescent Patients
- Sleep Disorders
- Accidental Geriatrician

9:00 AM
Board Meeting
Michigan Allergy Society

12 Noon
Lunch for All Registrants
Luncheon
MSMS Committee on Concerns of Women Physicians
Luncheon
MSMS Specialty Society Presidents

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*
- Allergy and Asthma
- Colorectal Cancer
- Dermatology
- Fertility and Pregnancy at 35
- Environment and Illness
- Thyroid Disease
- Radiology
- Sexuality
- Aging Gut
- Urology

3:00 PM
Board Meeting/Reception/Dinner/Program
Michigan Orthopaedic Society

6:00 PM
Reception
Michigan State University College of Human Medicine Alumni Association
Reception
Wayne State University Medical Alumni Association

6:30 PM
Reception/Dinner
MSMS Physician Service Group, Inc.

THURSDAY, NOVEMBER 9

7:00 AM
"Early Bird" Plenary Session on Hepatitis B
Hubbard Ballroom *(Coffee & Rolls included)*

7:30 AM
Great Lakes Exhibit Center Open
Registration

8:30 AM
Concurrent Scientific Courses *(run until Noon)*

- Acute MI
- Basic Cardiac Life Support
- ENT in Children
- Falls in the Elderly
- Leg/Back Pain
- Neurology
- Maxillofacial Reconstruction
- Ulcer Disease
- Trauma Education

12 NOON
Lunch for All Registrants

1:30 PM
Concurrent Scientific Courses *(run until 5:00 p.m.)*

- Brain and Heart
- Plastic Surgery
- Electrolyte and Acid Base Problems
- Patients on Workers Compensation
- Psychoactive Drug Use & Misuse
- HIV Positive Patient
- Violence Within Families
- Sinus Disease

6:00 PM
Reception/Dinner/Meeting
Michigan College of Nuclear Medicine Physicians

Schedule of Special Events

☐ **Clinical Poster Displays** *(all day)*
Tuesday and Wednesday,
November 7-8

☐ **"Early Bird" Plenary Sessions I and II**
Hubbard Ballroom
(Coffee & Rolls included)
Wednesday, November 8 at 7 a.m.
Thursday, November 9 at 7 a.m.

☐ **MSMS ASM Planning Committee**
Reception
Tuesday, November 7 at 6:00 p.m.

☐ **MSMS Committee on Concerns of Women Physicians**
Luncheon
Wednesday, November 8 at 12:00 Noon

☐ **MSMS Committee of Specialty Society Presidents**
Luncheon
Wednesday, November 8 at 12:00 Noon

☐ **MSMS Physician Service Group, Inc.**
Reception/Dinner
Wednesday, November 8 at 6:30 p.m.

☐ **Michigan Allergy Society**
Board Meeting at 9:00 a.m.
Wednesday, November 8

☐ **Michigan College of Nuclear Medicine Physicians**
Reception/Dinner/Meeting
Thursday, November 9 at 6 p.m.

☐ **Michigan Orthopaedic Society**
Board Meeting/Reception/
Dinner/Program
Wednesday, November 8 at 3 p.m.

☐ **Michigan State University College of Human Medicine Alumni Association**
Reception
Wednesday, November 8 at 6:00 p.m.

☐ **Wayne State University Medical Alumni Association**
Reception
Wednesday, November 8 at 6:00 p.m.

Choose from 55 Category 1 Courses

Tuesday morning, November 7

All courses run from 8:30 to noon with half-hour break

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

☐ Assessment and Treatment of Depressive Disorders

PRESENTED BY: Department of Psychiatry, University of Michigan Medical Center

This course will improve the primary care physician's skill in diagnosing and treating depressive disorders. Lecture and video tapes will cover the range of depressive moods from normal grief reaction to manic-depressive disorders. Laboratory tests for depression will be reviewed and guidelines given for use of lab tests in clinical practice. The latest developments in anti-depressant medications and the rationale for use of different medications will be provided. Indicators for electroconvulsive therapy and video of an actual ECT procedure will be shown.

COURSE CO-DIRECTORS: **John F. Greden, MD,** Professor and Chairman, Department of Psychiatry, University of Michigan Medical Center; Research Scientist, Mental Health Research Institute, Ann Arbor and **David L. Neal, ACSW, CSW,** Assistant Professor of Social Work, Department of Psychiatry, University of Michigan Medical Center

☐ Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course

COURSE DIRECTOR: **Robert K. Orr, Jr., DO**, Associate Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

☐ Congestive Heart Failure: Update on Diagnosis & Treatment

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics

In this course, the pathophysiology, diagnosis, and treatment of congestive heart failure will be presented. There will be a section discussing new drugs on the horizon. Adequate time will be allowed for questions and answers along with an open panel discussion.

COURSE DIRECTOR: **George L. Royer, Jr., MD,** The Upjohn Company, Kalamazoo

☐ Critical Care: Practical Points for the Primary Care Physician

PRESENTED BY: Division of Critical Care/Pulmonary Medicine, Wayne State University School of Medicine

This course, directed toward primary care physicians, will review recent advances in pathophysiology and principles of management in acute care medicine. Presentations will include discussion of oxygen transport and utilization in the critically ill; estimating and providing nutritional needs in the ICU; ventilation and oxygenation emphasizing newer mechanical techniques for respiration and weaning; and the complex pathophysiology of sepsis/ARDS and therapeutic strategies. There will be time for questions and answers after the lectures.

COURSE DIRECTOR: **Richard W. Carlson, MD, PhD,** Professor and Chief, Department of Pulmonary/Critical Care Medicine, Department of Internal Medicine, Wayne State University School of Medicine; Chief, Internal Medicine, Detroit Receiving Hospital

☐ Current Status of Magnetic Resonance Imaging and Spectroscopy

PRESENTED BY: Department of Radiology, Michigan State University College of Human Medicine

This course will discuss the clinical use of magnetic resonance, as well as magnetic resonance vascular flow imaging, prospects for spectroscopy in neuroscience and skeletal muscle. Diagnosis of brain, spinal and musculoskeletal disease will be emphasized. Time will be reserved for questions and answers after each presentation, concluding with a panel discussion.

Alexander

Blakley

Breiner

Brody

Burney

Davies

Ditmars

COURSE DIRECTOR: **E. James Potchen, MD,** Professor and Chairman, Department of Radiology, Michigan State University College of Human Medicine

☐ Industry & The Environment

PRESENTED BY: Michigan Occupational Medical Association

This course will show the relationship between environment and industry from three different aspects. It will demonstrate how co-workers in the same industrial environment influence one another, how robots will change the internal environment of industry and will demonstrate industry's recognition of its responsibility to the external environment. Physicians in all specialties will learn how great an impact the environment has on their patients' health and the physicians' role in recognition, education and management.

COURSE DIRECTOR: **Leonard S. Zubroff, MD,** Retired Regional Medical Director, General Motors Corporation

☐ Pain and Symptom Control for Patients with Advanced or Terminal Cancer

PRESENTED BY: Department of Family Medicine, Wayne State University School of Medicine

This course will cover the use of the hospice approach to pain and symptom management in terminally ill cancer patients. It will review oral, parenteral and special anesthesiological techniques for medication delivery. The focus will be on home care of the terminal patient in a hospice context. At the completion of this course the participant will be able to: 1) Make an appropriate referral to a hospice program and work cooperatively with the hospice team, 2) write and monitor orders for oral morphine and adjuvant drugs to handle the five common causes of terminal malignant pain, 3) write and monitor orders for the management of a group of common noxious symptoms other than pain in the terminal patient, and 4) understand the special techniques of spinal and nerve block pain control available through an experienced anesthesiologist.

COURSE DIRECTOR: **Paul T. Werner, MD,** Associate Professor and Associate Chairman, Department of Family Medicine, Wayne State University School of Medicine

☐ Review of Ear Problems

PRESENTED BY: Department of Otolaryngology, Wayne State University School of Medicine

This course will outline rational evaluation and treatment plans for many common ear problems and areas critical to the needs of primary care physicians will be stressed. The focus of the course will be on clinical management rather than research studies and will include topics such as dizziness, ear pain, otorrhea, serous otitis, tinnitus and hearing aids. There will be ample time for questions and discussion of participants' cases.

COURSE DIRECTOR: **Brian W. Blakley, MD, PhD,** Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine; neurotologist, Harper Hospital, Detroit

☐ The New Arthritides

PRESENTED BY: Michigan Rheumatism Society

Rheumatology has changed! In the 1980's five previously unrecognized conditions came to the attention of medicine: Lyme Arthritis, AIDS associated arthritis, Milwaukee Shoulder, eosinophilic fasciitis and recurrent osteolysis of bone. The purpose of our presentation is to acquaint physicians with the features of these conditions, their recognition and management. In addition, we will discuss how investigations into these entities resulted in understandings applicable to a wider field of rheumatologic disorders.

COURSE DIRECTOR: **Joseph J. Weiss, MD**, Private Practice, Livonia; Michigan Rheumatism Society

Tuesday afternoon, November 7

All courses run from 1:30 to 5 p.m. with half-hour break

1989 MSMS ANNUAL
SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

☐ Breast Cancer: Diagnosis and Management

PRESENTED BY: Department of Surgery, Michigan State University College of Human Medicine

This course will update the primary care physician on the current status of breast cancer screening and the clinical and radiographic indications for breast biopsy. A case presentation and panel discussion format will be used to present the current options and controversies in the management of noninvasive and invasive breast cancer.

COURSE DIRECTOR: **Carol A. Slomski, MD,** Assistant Professor, Department of Surgery, Michigan State University College of Human Medicine

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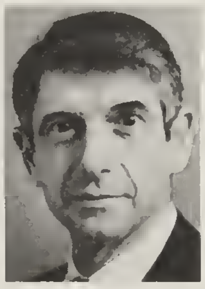
Ellenberg

Finch

Fleck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Greden

Green

☐ Care of the Medical/Social High-Risk Patient: Newborn to Infant

PRESENTED BY: Michigan Chapter, American Academy of Pediatrics

This course will intially focus on the placenta as a reflection of intrauterine life with a discussion of changes found in the placenta as a result of intrauterine infection, malimplantation and exposure to drugs and teratogens. The immediate and long term complications of maternal drug abuse on the neonate will be discussed. Neonatal HIV and cocaine exposure and state of the art techniques to diagnose these conditions will be presented. Lastly, the pediatrician and family physicians approach to the follow-up of high risk neonates with emphasis on monitoring of growth, development, vision, language and auditory follow-up will be discussed.

COURSE DIRECTOR: **Seetha Shankaran, MD,** Director, Neonatal-Perinatal Medicine, Children's Hospital of Michigan and Wayne State University School of Medicine

☐ Childhood Depression: A Family Affair

PRESENTED BY: Department of Psychiatry, University of Michigan Medical Center

This course will provide pediatricians and primary care physicians the latest knowledge about how to diagnose childhood and adolescent depressive disorders. Lectures and video tapes of depressed children will depict how this illness can reveal itself in different ways and make diagnosing the disorder difficult. The latest developments in medications and psychotherapies for children and families will be reviewed. How depressive disorders can affect marital and family relationships will be discussed as well as intervention strategies.

COURSE CO-DIRECTORS: **John F. Greden, MD,** Professor and Chairman, Department of Psychiatry, University of Michigan Medical Center; and Research Scientist, Mental Health Research Institute, Ann Arbor and **David Neal, ACSW, CSW,** Assistant Professor of Social Work, Department of Psychiatry, University of Michigan Medical Center

☐ Gastrointestinal Surgery for the Non-Surgeon

PRESENTED BY: Department of Surgery, Wayne State Unversity School of Medicine

This course is for referring and consulting physicians interested in a review of the indications for operation, latest treatments and complications of relatively common diseases frequently requiring surgery. The faculty will discuss the following topics: esophagitis, esophageal stricture, perforated ulcer, bleeding ulcer, cholelithiasis, cholangitis, pancreatitis and pancreatic pseudocyst. Each of the four talks will last 35 minutes and there will be a 10 minute panel discussion after each presentation.

COURSE DIRECTOR: **David Fromm, MD,** Professor and Chairman, Department of Surgery, Wayne State University School of Medicine

☐ Managing Difficult Physician-Patient Relationships

PRESENTED BY: University of Michigan Family Practice Center, Chelsea

Difficult physician-patient interactions are often those which leave the provider feeling confused, angry, frustrated or disgusted. This course will attempt to teach physicians how to identify and appropriately manage these situations. The basic principles of family systems theory and their application to the physician-patient relationship will be presented. It is hoped that physicians will examine issues from their own lives which may be affecting their work and will also understand the relevance of these principles to their patients' behaviors. Course attendees will be asked to present cases from their practices for which the presenters will serve as consultants.

COURSE CO-DIRECTORS: **S. Margaret Davies, MD,** Assistant Professor of Family Practice, University of Michigan, Department of Family Practice and **Samuel E. Romano, PhD,** Instructor and Clinical Psychologist, University of Michigan, Department of Family Practice.

☐ Orthopaedics in Family Practice

PRESENTED BY: Michigan Orthopaedic Society

This course will present a review of selected topics for primary care physicians from the field of orthopaedics. Among the subjects will be scoliosis school screening, osteoporosis, occupational problems in the upper extremity and lower extremity evaluation in infants and children. Participants will have the opportunity to ask questions of each speaker.

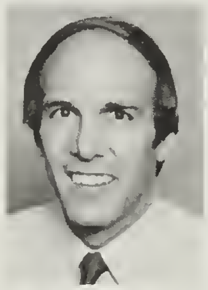
COURSE DIRECTOR: **W. John Bruder, MD,** Vice-President, Michigan Orthopaedic Society; Orthopaedic Surgeon, Munson Medical Center, Traverse City

☐ Perioperative Risk Management in Surgery and Obstetrics

PRESENTED BY: Michigan Society of Anesthesiologists and Department of Anesthesiology, University of Michigan Medical School

All physicians involved in the preparation and actual performance of anesthesia and surgery in both obstetrical and surgical patients will be made aware of the commonly occurring areas for patient risk. This course, utilizing existing guidelines and

Kahkonen


Kass

Kuvin

Mayle

Meier

Migdal

Morrell

standards as a starting point, will review the entire perioperative period from evaluation to recovery room discharge in a series of 20 minute lectures. At the end of the formal lectures the panel of speakers will participate with the audience in a general discussion of the subject.

COURSE CO-DIRECTORS: **Gaylord D. Alexander, MD,** Associate Professor of Anesthesiology, Wayne State University School of Medicine and **Jay S. Finch, MD,** Professor and Chairman, Department of Anesthesiology, University of Michigan Medical School

☐ *Safe Weight Loss*

PRESENTED BY: Michigan Health Council and Michigan Department of Public Health

This course is intended for physicians with clinical or administrative duties related to weight loss care. A panel will report recommendations of the Task Force to Establish Weight Loss Guidelines for Michigan, which have been endorsed by 43 health organizations. Physicians completing the course will be aware of preventable side effects from weight loss, as well as the guidelines for health supervision, nutrition, exercise, and psychosocial support. Screening criteria, clinical data base for care plan development, and medical-legal implications will be discussed.

COURSE DIRECTOR: **Maurice Reizen, MD, MSPH,** MSMS Liaison to Weight Loss Task Force

☐ *The Eye as a Window to Systemic Disease*

PRESENTED BY: Michigan Ophthalmological Society

This course will review and discuss the ocular presentation and manifestation of systemic disease. Topics to be covered include: diabetes, hypertension, collagen vascular disease, sexually-transmitted disease including AIDS, thyroid disease and neurologic disease. Individual cases will be presented using ocular and fundus photography for presentation of clinical features.

COURSE DIRECTOR: George A. Williams, MD, Associate Clinical Professor, Department of Ophthalmology, Wayne State University School of Medicine, William Beaumont Hospital, Royal Oak

☐ *Update on Ethics: Three Current Concerns*

PRESENTED BY: Medical Ethics Resource Network and MSMS Committee on Bioethics

There will be three one-hour segments to this course. The first segment will address continuing concerns with withdrawing and withholding life-sustaining treatments. The second segment will address ethical issues in the NICU, especially strategies for making good decisions in the face of great uncertainty. The third segment will address issues of justice connected with efforts at health care cost containment in the Medicaid program in Michigan. The issue of justice includes fair treatment for Medicaid clients as well as physicians and hospitals/nursing homes. Each session will involve a half-hour presentation followed by audience questions and case discussion.

COURSE CO-DIRECTORS: **Howard Brody, MD, PhD,** and **Leonard M. Fleck, PhD;** Center for Ethics and Humanities in the Life Sciences, Michigan State University College of Human Medicine

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Wednesday morning, November 8

"Early Bird" Plenary Session

"DRUG ABUSE: A THREAT TO THE NATION'S HEALTH"

Hubbard Ballroom
Continental Breakfast at 7:00 a.m.
Presentation at 7:15 a.

Beny J. Primm, MD

Executive Director, Addiction Research and Treatment Corporation, Urban Resource Insitute, New York, NY

Come early and have breakfast. There is no fee for this program and it offers 1 hour of Category I CME credit.

Neal

O'Brien

O'Neill

Orr

Pasik

Potchen

Reizen

Wednesday morning, November 8

All courses run from 8:30 to noon with half-hour break

☐ *Antimicrobial Therapy*

PRESENTED BY: Division of Infectious Diseases, Wayne State University School of Medicine

This course is aimed at bringing practitioners up-to-date with the numerous new antimicrobial agents available today. Physicians in all specialties will learn the current application of such new agents as antibacterial, antiviral and antifungal drugs.

COURSE DIRECTOR: **Jack D. Sobel, MD,** Professor, Department of Medicine, Wayne State University School of Medicine

☐ *Basic Cardiac Life Support*

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical stations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: **Robert K. Orr, Jr., DO,** Associate Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

☐ *Emergency Management of Poisonings and Overdoses*

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course will provide the primary care physician with an update on common specific problems associated with the presentation and management of these poisonings and overdoses. It will be of benefit to physicians working primarily in emergency departments and primary care physicians called upon to handle these types of cases both in the emergency department and in the immediate post-admission stage. Each topic will consist of a presentation followed by a question and answer period.

COURSE DIRECTOR: **Anthony C. Southall, MD,** Chief, Department of Emergency Medicine, St. John Hospital, Detroit; Michigan Chapter, American College of Emergency Physicians

☐ *Hypercholesterolemia: From Eight to Eighty*

PRESENTED BY: Department of Internal Medicine, Henry Ford Hospital

This course will review the diagnosis and management of hypercholesterolemia, providing guidelines for intervention which can be used by primary care physicians. Therapeutic recommendations for children and the elderly will be discussed.

COURSE DIRECTOR: **Dorothy M. Kahkonen, MD**, Co-Director, Lipid Clinic, Henry Ford Hospital, Detroit

☐ *Methods and Ethics of New Reproductive Technologies*

PRESENTED BY: MSMS Committee on Concerns of Women Physicians

The course will focus on the medical, psychological, and ethical implications of the new reproductive technologies. Presentations will provide information on the new techniques for impregnation and the types of patients suitable for these procedures. They will discuss the psychological reactions of prospective parents, and will discuss the implications for all individuals and the impact on future family life.

COURSE DIRECTOR: **Dawn E. Springer, MD,** Mason, Chairman, MSMS Committee on Concerns of Women Physicians

☐ *Primary Care for Women*

PRESENTED BY: Michigan Section, American College of Obstetricians and Gynecologists

This course, directed toward primary care physicians, will provide practical information on evaluation and management of commonly occurring gynecologic problems. Presentations will discuss the yearly exam, STDs, menopause and stress incontinence. The course will provide the most current information in management related to these topics and will be valuable to family physicians as well as other specialists. There will be time allowed for questions and answers from the audience.

COURSE DIRECTOR: **Charles C. Vincent, MD,** Department of Obstetrics and Gynecology, Wayne State University School of Medicine/Hutzel Hospital

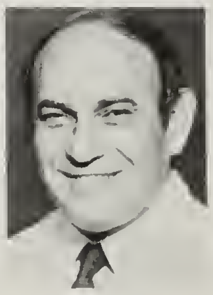
Ripley

Romano

Schubiner

Shankaran

Slomski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Southall

☐ *Screening & Prevention in Adolescent Patients*

PRESENTED BY: Departments of Internal Medicine and Pediatrics, Wayne State Unversity School of Medicine

This course will offer the primary care physician an organized approach to the care of adolescent and young adult patients. Identification and management of the unique issues presented by teens requires special knowledge and skills. Through a combination of didactic and videotaped interactive presentations, participants will become familiar with the preventive health care of the adolescent and young adult patient. Special emphasis will be given to interviewing techniques and the pre-participation sports physical.

COURSE DIRECTOR: **Howard Schubiner, MD,** Assistant Professor, Division of General Internal Medicine-Pediatrics, Wayne State University School of Medicine

☐ *Sleep Disorders in Primary Care Medicine*

PRESENTED BY: Department of Medical Education, Oakwood Hospital

Sleep disorders medicine has rapidly developed into a major clinical discipline since the first descriptions of the Pickwickian Syndrome and Sleep Apnea just a few decades ago. With increasing public awareness of sleep problems, the primary care physician can play a pivotal role in the diagnosis and treatment of these disorders. The course will be introduced by first discussing the basic physiology and stages of sleep in addition to circadian rhythms and jet lag. Speakers will then address the common disorder of insomnia and the uncommon, but fascinating, problem of narcolepsy. An in-depth discussion of the life threatening disorder of sleep apnea will also be provided. At the conclusion of the course participants should have a basic understanding of sleep disorders medicine and the clinical approach to the sleepy patient.

COURSE DIRECTOR: **Lyle D. Victor, MD,** Assistant Director of Medical Education, Oakwood Hospital, Dearborn

☐ *The Accidental Geriatrician*

PRESENTED BY: Department of Family Medicine, Wayne State University School of Medicine

All physicians will have increasing exposure to the elderly due to aging of the population. These "accidental geriatricians" need a basic orientation to the special issues helpful in caring for the elderly. At the completion of this course, the participant will have gained information in epidemiology and demography of the aged, physiology of aging, atypical presentation of disease in the elderly, functional assessment of the elderly, social and psychologic issues in the elderly and elements of good prescribing for the elderly.

COURSE DIRECTOR: **Paul T. Werner, MD,** Associate Professor and Associate Chairman, Department of Family Medicine; Director of Geriatrics, Wayne State University School of Medicine

Wednesday afternoon, November 8

All courses run from 1:30 to 5 p.m. with half-hour break

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

☐ *Allergy and Asthma Update: 1989*

PRESENTED BY: Michigan Allergy Society

This course is designed for both the allergist and non-allergist. It will provide an update on a number of timely allergy and asthma topics such as the management of asthma, the diagnosis and management of drug allergy, and the importance of recognizing the asthmatic with allergic bronchopulmonary aspergillosis. The course will utilize a lecture format with time allotted for questions.

COURSE DIRECTOR: **Lawrence I. Pasik, MD**, President of Michigan Allergy Society, West Bloomfield

☐ *Colorectal Cancer - The Silent Epidemic*

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course is designed to provide practical information about the diagnosis and management of colorectal cancer. With 150,000 new cases of colorectal cancer each year and nearly 60,000 deaths from this disease annually, this truly represents a silent epidemic. The course will focus on the early detection of colorectal polyps and cancer with a review of current screening techniques and recommendations for manage-

Springer

Surrell

Victor

Vincent

Weiss

Werner

Wilcox

ment. Also, the newer modalities for the diagnosis and treatment of rectal cancer including intrarectal ultrasound will be reviewed. Only through the early detection of colorectal polyps and earlier diagnosis of colorectal cancer, can we hope to improve the long-term survival from this common adult cancer.

COURSE DIRECTOR: **James A. Surrell, MD**, Colorectal Surgeon, Ferguson Clinic, Grand Rapids

☐ Dermatology: Melanoma 1989

PRESENTED BY: Michigan Dermatological Society

This course will present an update on malignant melanoma with particular emphasis on the biology of melanoma metastasis and biological therapy of malignant melanoma metastasis. The objective will be to create an understanding of biological concepts which may be the basis for future therapy of this potentially fatal disease. Pigmented lesions in childhood will be reviewed with emphasis on those lesions which have the potential to become malignant. Surgical treatment of cutaneous melanomas will also be discussed. This course will be of interest to dermatologists, internists, oncologists, and surgeons.

COURSE DIRECTOR: **Margaret C. Douglass, MD,** Department of Dermatology, Henry Ford Hospital, Detroit

☐ Fertility and Pregnancy at 35-Plus: Is it Different?

PRESENTED BY: Department of Obstetrics, Gynecology and Reproductive Biology, Michigan State University College of Human Medicine

This course is designed to discuss problems in fertility and obstetrical care as they relate to women in the 35 year-old and older age group. It should be of interest to any physician involved in the care of female patients in this age category who are potential candidates for pregnancy as well as those physicians who deliver obstetrical care. The discussions will include issues related to fertility, preconceptual counseling, prenatal diagnosis and parturition. The format will include a brief pretest followed by a series of presentations related to those topics with sufficient time allotted for a panel question and answer period.

COURSE DIRECTOR: **Eugene W. Mauch, MD,** Associate Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

☐ Is My Environment Making Me Sick, Doctor?

PRESENTED BY: Michigan Department of Public Health and Michigan State Medical Society Liaison Committee with MDPH

The course is designed to give medical practitioners background to deal with questions that arise about health threats from our environment. The course will deal with how "safe" levels of chemicals in our environment are determined, problems of illness related to indoor air contamination, and how to approach reports of "clusters" of disease, such as cancer, through presentation of background material and discussion. Information will be given to answer concerns and questions that are continually cropping up about a wide range of topics, such as, radon, Legionnaire's Disease, sport fish, water chemicals and second hand tobacco smoke

COURSE DIRECTOR: **Kenneth R. Wilcox, Jr., MD, PhD,** Chief Medical Executive, Michigan Department of Public Health; Member, MSMS Liaison Committee with MDPH, Lansing

☐ Optimizing Thyroid Disease Diagnosis

PRESENTED BY: Department of Nuclear Medicine, William Beaumont Hospital and Michigan Thyroid Association

This course will provide the primary care physician with the latest information on the most efficacious approach to diagnose and manage thyroid disease. Special emphasis will be given to thyroiditis, thyroid disease in the elderly, and the uses and abuses of thyroid imaging through three presentations followed by individual question and answer periods.

COURSE DIRECTOR: **Donald Meier, MD,** Associated Endocrinologists, West Bloomfield

☐ Radiology for Clinicians

PRESENTED BY: Department of Radiology, Wayne State University School of Medicine and Detroit Medical Center Hospitals

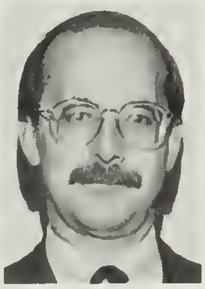
This course will provide primary physicians practical information in the approach of common clinical problems using various diagnostic modalities. Indications and uses of diagnostic ultrasonography in the evaluation of various pelvic abnormalities will be presented. Indications and guidelines for mammography will be discussed. Common radiological interventional procedures in the management of various clinical problems will be described. Evaluation of various musculo-skeletal abnormalities with the newest modality, MRI will be covered, followed by a question and answer period.

COURSE DIRECTOR: **Alkis P. Zingas, MD,** Clinical Assistant Professor, Department of Radiology, Harper Hospital, Detroit

☐ Sexuality and Sexual Problems

PRESENTED BY: Michigan Psychiatric Society

This clinically oriented course is directed towards family physicians, pediatricians, obstetricians, gynecologists, orthopedics, physical medicine/rehabilitation, and urologists. Among


Williams

Yaremchuk

Zingas

Zubroff

the topics that will be covered from this broad field are varied emotions underlying sexuality, sexual problems of and solutions for the disabled, trans-sexualism, transvestism, homosexuality, sexual activity and pathology in childhood, dyspareunia, vaginismus, impotence, and sexuality in the elderly. Questions from the audience will be encouraged.

COURSE DIRECTOR: **Sander J. Breiner, MD, FAPA**, Associate Professor, Department of Psychiatry/Psychoanalysis, Michigan State University College of Human Medicine and Wayne State University School of Medicine

☐ *The Aging Gut*

PRESENTED BY: Department of Medicine, Michigan State University College of Human Medicine

This course for primary physicians will review the pathophysiological effects of advancing age on gastrointestinal tract. Reviews of specific clinical disorders will be presented in 20 - 30 minute lectures. Specific cases will be presented for small group discussion of diagnostic and therapeutic management. Course participants will, at the end of this course, be better prepared to approach GI symptoms and disorders in their geriatric patients.

COURSE DIRECTOR: **James E. Mayle, MD,** Associate Professor, Michigan State University College of Human Medicine

☐ *What's New in Urology*

PRESENTED BY: Michigan Urological Society

This course will update the practicing physician about recent developments in the field of urology. The course is directed to primary care physicians and will emphasize practical information as to the advantages and disadvantages of these new concepts. Ample time will be reserved for questions and audience participation.

COURSE DIRECTOR: **Evan J. Kass, MD,** Chief, Pediatric Urology, William Beaumont Hospital, Royal Oak

Thursday morning, November 9

All courses run from 8:30 to noon with half-hour break

1989 MSMS ANNUAL SCIENTIFIC MEETING
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"Early Bird" Plenary Session

"PROTECTING THE HEALTH OF THE AMERICAN PEOPLE AGAINST HEPATITIS B"

Hubbard Ballroom
Continental Breakfast at 7:00 a.m.
Presentation at 7:15 a.m.

Sanford F. Kuvin, MD
Vice Chairman, Board of Trustees\National Foundation for Infectious Diseases, Palm Beach, Florida

Come early and have breakfast. There is no fee for this program and it offers 1 hour of Category I CME credit.

☐ *Acute MI from ER and Beyond*

PRESENTED BY: Division of Cardiology, William Beaumont Hospital

This course, directed toward primary care physicians and other specialists, will discuss management of acute myocardial infarction from the emergency room to follow-up care. Topics will include emergency room evaluation and early therapy; patient selection and choice of thrombolytic agents; role of invasive therapy and risk evaluation, follow-up therapy. There will be a panel discussion with time for questions and answers from the participants.

COURSE DIRECTOR: **William W. O'Neill, MD,** Clinical Associate Professor, Department of Medicine, University of Michigan Medical School and Director, Division of Cardiology, William Beaumont Hospital, Royal Oak

☐ *Basic Cardiac Life Support*

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical stations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: **Robert K. Orr, Jr., DO,** Associate Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

☐ *Common ENT Problems in Children*

PRESENTED BY: Division of Pediatric Otolaryngology, Henry Ford Hospital

The four presentors will discuss an updated approach in the psychiatric patient for the primary physician with respect to: stridor and airway distress; hoarseness and common voice disorders; hearing loss - congenital and acquired; tonsillectomy and adenoidectomy - when are they indicated.

COURSE DIRECTOR: **Norman J. Novelly, DO,** Head, Division of Pediatric Otolaryngology Henry Ford Hospital, Detroit

☐ Falls in the Elderly

PRESENTED BY: MSMS Committee on Aging

This course will describe the epidemiology of falls in the elderly and intrinsic and trinsic risk factors. Emphasis will be placed on the assessment of the elderly patient in order to determine those most at risk for falling and interventions will be discussed based on the identified gait deficiency.

COURSE DIRECTOR: **Phillip M. Green, MD,** Physician Director of Gerontology, Borgess Geriatric Center, Kalamazoo

☐ Leg and/or Back Pain and Dysfunction: Diagnosis and Management

PRESENTED BY: Departments of Rehabilitation Medicine and Internal Medicine, Sinai Hospital of Detroit

This course, through actual patient presentation and demonstration using video camera enhancement, multidisciplinary panel reaction and discussion, will review and demonstrate the diagnosis, mechanics and treatment of some of the causes of leg and/or back pain and dysfunction. Diseases of the lumbosacral spine, articular structures, tendons and nerves will be discussed. Gait abnormalities and their significance will be presented. Upon completion of the course, physicians involved in primary care of adult patients should understand some of the techniques of physical examination of the back and lower extremities, be able to diagnose some problems which cause leg dysfunction, have some understanding of the mechanics and treatment of these problems, and also be aware of the use of electrodiagnostic testing in helping to evaluate and diagnose leg and/or back pain and dysfunction.

COURSE DIRECTOR: **Maury R. Ellenberg, MD,** Senior Associate Attending, Department of Rehabilitation Medicine, Sinai Hospital of Detroit

☐ New Neurology-The Common and The Uncommon

PRESENTED BY: Greater Ann Arbor Neurology Associates, PC

This course, directed to physicians of many specialties, will review recent advances in neurology and how they affect concepts, diagnosis and management of common and uncommon neurological disorders. Among topics included will be practical office management of dementia, TIA syndrome, pain (including headache), closed head injury, seizures and neuromuscular disorders. Time will be allowed for questions and answers.

COURSE DIRECTOR: **Roger M. Morrell, MD, PhD, FACP,** Greater Ann Arbor Neurology Associates, PC

☐ Priorities In Maxillofacial Reconstruction

PRESENTED BY: Michigan Academy of Plastic Surgeons

Principles involved in maxillofacial repair and reconstruction will be outlined and applied to esthetic plastic surgery and cleft lip and palate. The program is directed to practicing plastic surgeons and residents in training.

COURSE DIRECTOR: **Donald M. Ditmars, Jr., MD,** Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

☐ The Spectrum of Ulcer Disease - 1989

PRESENTED BY: Department of Clinical Education, Wayne State University School of Medicine, Division of Gastroenterology

The course will provide generalists and specialists an update on peptic ulcer disease including pathogenesis and pathophysiology. The problems of stress bleeding, NSAID-induced gastropathy, and peptic disease in the elderly will be featured along with the newest principles of management. There will be ample time for questions after the lecture presentations.

COURSE DIRECTOR: **Murray N. Ehrinpreis, MD,** Assistant Professor, Department of Medicine, Wayne State University School of Medicine

☐ Trauma Education Programs for Primary Care Physicians

PRESENTED BY: Michigan Committee on Trauma, American College of Surgeons

This course will introduce trauma education programs and materials of interest to primary care physicians currently available from the American College of Surgeons. Topics will include trauma system rationale and organization and a brief overview of the Advanced Trauma Life Support Course with specific information about initial priorities of care. Information regarding current recommendations for tetanus immunization, initial care of burns and soft tissue injuries, and trauma scoring and evaluation methods will also be presented. Time will be allowed for questions from attendees regarding trauma care.

COURSE DIRECTOR: **Richard E. Burney, MD,** Chief, Emergency Services, Department of Surgery, University of Michigan Medical School

Thursday afternoon, November 9

All courses run from 1:30 to 5:00 p.m. with half-hour break

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☐ Brain and Heart: 1989

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course will emphasize the role of perfusion imaging in the clinical evaluation of the heart and brain using contemporary nuclear medicine procedures and sophisticated positron emission tomographic techniques. The value of thallium imaging of the myocardium in the diagnosis, treatment and prognosis of patients with coronary artery disease will be discussed. The clinical utility of myocardial PET scanning and perfusion imaging, particularly in patients suffering from dementia seizure disorders and post-traumatic head injury, will also be discussed. This course will be useful to the generalist and specialist who manage patients with these disorders in their daily practices.

COURSE DIRECTOR: **Shawn D. Ripley, MD, FRCP,** Metropolitan General Hospital, Windsor, Ontario, Canada

☐ Clinical & Research Studies in Common Plastic Surgery Problems

PRESENTED BY: Michigan Academy of Plastic Surgeons

A series of papers will present topics pertinent to clinical practice problems encountered commonly with recommendations based upon research and long term follow-up. Course directed towards practicing plastic and hand surgeons and residents in training.

COURSE DIRECTOR: **Donald M. Ditmars, Jr., MD,** Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

☐ Current Concepts in the Management of Electrolyte and Acid Base Problems

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine and Harper Hospital

This course will provide the practicing physician with an overview of current concepts in the pathogenesis, diagnosis and treatment of common disorders of electrolytes and acid base metabolism. The specific disorders to be addressed will be abnormalities of serum sodium, potassium, and metabolic acidosis and alkalosis. These topics will be presented in four didactic lectures followed by a discussion of representative case management problems which will be distributed before the course.

COURSE DIRECTOR: **Stephen D. Migdal, FACP, MD,** Associate Professor, Department of Medicine; and Chief, Nephrology Section, Wayne State University School of Medicine/ Harper Hospital

☐ Management of Your Patient on Workers Compensation

PRESENTED BY: Rehabilitation Institute, Wayne State University School of Medicine - Physical Medicine and Rehabilitation

This course will provide primary physicians with practical information for the evaluation and management of physical and nonphysical problems presented by the patient on workers compensation. Presenters will discuss immediate and post-traumatic interventions including indicators of nonphysical factors contributing to disabling conditions. Time will be provided for discussion, questions and answers.

COURSE CO-DIRECTORS: **Adel El-Magrabi, MD,** Staff Physiatrist, Rehabilitation Institute, Detroit and **Daniel D. Tomaszewski,** Rehabilitation Institute, Detroit

☐ Psychoactive Drug Use & Misuse: A Psychiatric/Medical Controversy

PRESENTED BY: Michigan Psychiatric Society

This clinically oriented course is designed for every practicing physician. Among the topics covered will be the psychological dynamics of the drug abuser and the treatment potential. The clinical picture of various types of drug abuse, the indications and contraindications for psychoactive drug use, the different approaches by psychiatrists and non-psychiatrists in utilizing these drugs. Questions will be encouraged and extensive printed material will be distributed to participants.

COURSE DIRECTOR: **Sander J. Breiner, MD, FAPA,** Associate Professor, Department of Psychiatry, Michigan State University College of Human Medicine and Wayne State University School of Medicine

☐ The HIV Positive Patient: Symptoms, Care and Treatments

PRESENTED BY: MSMS AIDS Provider Education Project; WSU NIMH AIDS Education Project

This course will provide primary care physicians with practical information about the care and treatment of patients with HIV infection. The entire spectrum of treatment, including testing, diagnosis of infection and managing seropositive treatment for patients with HIV infection, will be presented during one hour segments. Questions and open dialogue will be encouraged during the time remaining.

COURSE DIRECTOR: **Evelyn J. Fisher, MD,** Department of Internal Medicine, Henry Ford Hospital, Detroit

☐ Violence Within Families

PRESENTED BY: MSMS Committee on Aging and Department of Family Practice, Michigan State University College of Human Medicine

This session will explore the problem of violence within families. The phenomenon of abuse and neglect will be discussed from a variety of perspectives including that of a pediatrician, a geriatrician, an attorney and a sociologist. The content will include a review of the phenomenon of abuse including causes, detection, reporting and management across generations. The format will include a series of didactic presentations with subsequent exchange between panelists and attendees. This program is targeted toward primary care physicians, psychiatrists, and emergency physicians.

COURSE DIRECTOR: **James G. O'Brien, MD,** Professor and Associate Chairman, Department of Family Practice, Michigan State University College of Human Medicine; Director, Geriatric Education Center; Director, Geriatrics Programs, St. Lawrence Hospital, Lansing

☐ Wiping Out Sinus Disease: The Sequel

PRESENTED BY: Department of Otolaryngology, Henry Ford Hospital

This course will provide a general approach for primary care physicians caring for patients with sinusitis. There will be discussion of diagnostic techniques and appropriate medical and surgical care. The role of sinus endoscopy for treatment of sinusitis with a video tape of surgery will be shown and surgical results in patients with chronic sinusitis and asthma will be reviewed. There will be time for questions and answers.

COURSE DIRECTOR: **Kathleen L. Yaremchuk, MD,** Senior Staff, Department of Otolaryngology, Henry Ford Hospital, Detroit

Plan to Visit These Firms' Exhibits

1989 MSMS ANNUAL SCIENTIFIC MEETING
November 7, 8, & 9
Hyatt Regency, Dearborn

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting November 7, 8, & 9 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be there to discuss the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the Annual Scientific Meeting and is the site of registration for all courses and special events. In addition, the deli luncheons and refreshments during breaks are served in the exhibit area.

To help you plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

☐ PHARMACEUTICALS

414	Boehringer Ingelheim Pharmaceuticals, Inc.
407	DuPont Pharmaceuticals
109	Allen & Hanburys (Division of Glaxo, Inc.)
412	Janssen Pharmaceutica
104	McNeil Consumer Products Company
402	Merck Sharp & Dohme
215	Miles, Inc., Pharmacy, Div.
308	Parke-Davis
311	Pfizer Laboratories Division
209	Princeton Pharmaceutical Products
302	Purdue Frederick
306	A.H. Robins Company
217	Schering Corporation
504	Smith Kline & French Laboratories
204	E.R. Squibb & Sons, Inc.
218-219	The Upjohn Company
413	Wyeth-Ayerst Laboratories

☐ CLINICAL LABORATORIES

222	Advance Medical/MetPath
313	Continental Bio-Clinical Laboratory Service, Inc.
310	Eagle Associates
110	Healthcare Laboratories, Inc.
108	Syntex Laboratories, Inc.

☐ IN-OFFICE EQUIPMENT AND SUPPORT

114	Bell Atlantic TriCon Leasing Corporation
410	Brentwood Instruments, Inc.
105	Cellular One
103	I.C. Systems, Inc.
304	Tri State Hospital Supply Corp.

☐ COMPUTERS/COMPUTER SERVICES

211	Bennethum Computer Systems
411	Colonial Valley Software, Inc.
408	CRT Management
220	Diversitec/Blue Cross & Blue Shield
305	Hewlett Packard
101, 505	Medical Billing Service
303	Office Technologies, Inc.
301	Professional Billing Systems, Inc.
106	Professional Practice Sales
312	Scientific Data Management Medical Computer Systems
205	Versyss Corporation

☐ EDUCATIONAL RESOURCES

403	J. B. Lippincott Company
307	W. B. Saunders

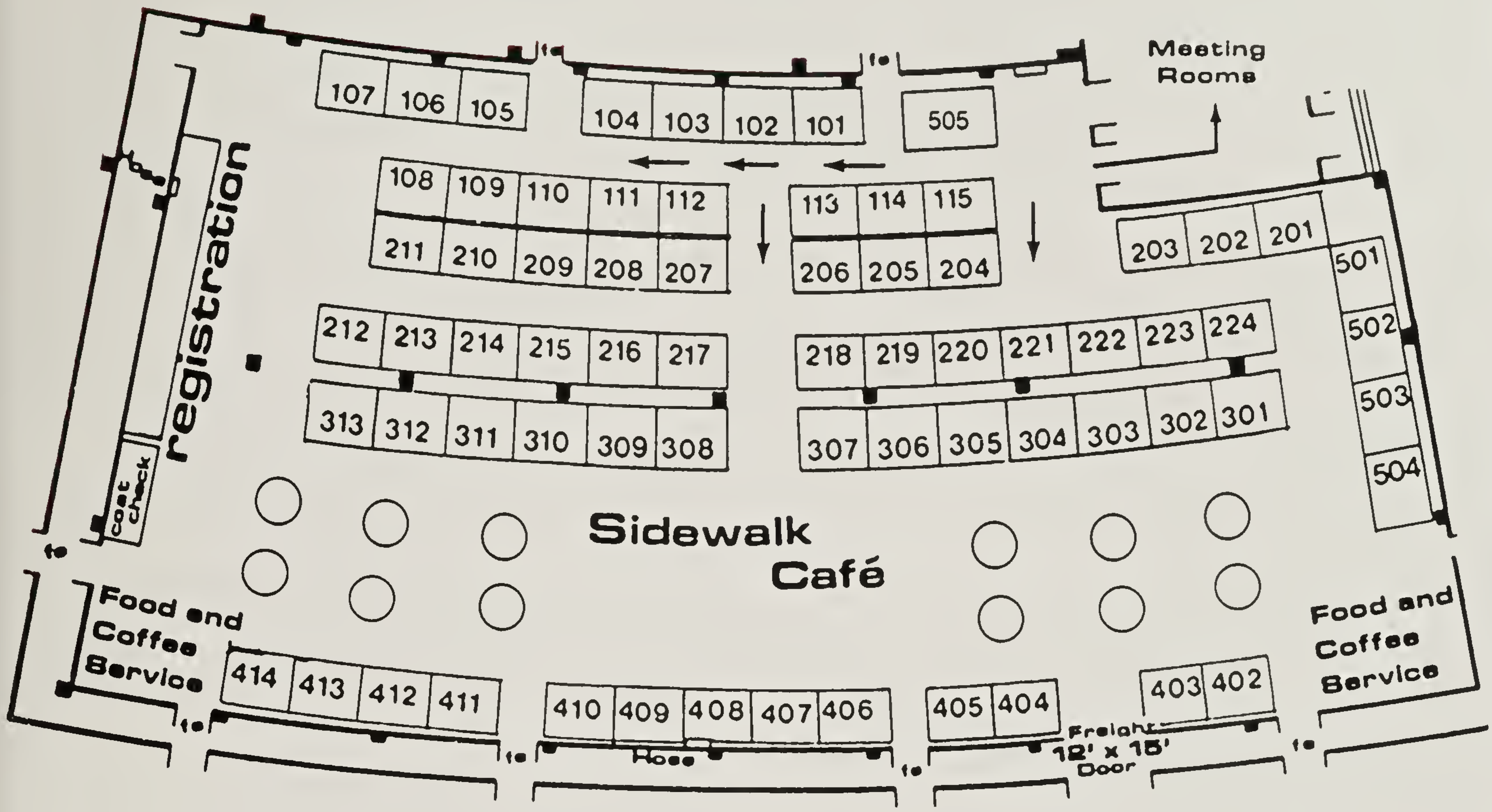
☐ PROTECTION

309	Blue Cross & Blue Shield of Michigan - Automated Input Concepts
206	Blue Cross & Blue Shield of Michigan - Field Services
113	Comerica Bank
406	Disability Determination Service
112	The Equitable - Association Members Retirement Program
207	Michigan Physicians Mutual Liability Company
102	Physicians Insurance Company of Michigan
115	Physicians Service Group, Inc.
405	Professional Asset Management, Inc.
221	Retirement Plan Consulting Group
208	Shearson Lehman Hutton
503	Stratton Cheeseman & Associates
107	Stratton Cheeseman Management Company, Inc.

☐ OTHER EXHIBITORS

201-203, 223-224	Henry Ford Hospital and Medical Centers
111	Randolph Medical, Inc.
212-214	University of Michigan Medical Center
501-502	Wyandotte Hospital and Medical Center

Great Lakes Exhibit Center


Meeting Rooms
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Food and Coffee Service
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Hose
Freight 12' x 15' Door

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Exhibit Information

Exhibit Hours:	
Tuesday	9:00 a.m. - 6:00 p.m.
Wednesday	9:00 a.m. - 6:00 p.m.
Thursday	9:00 a.m. - 5:00 p.m.
Coffee:	
Tuesday	7:30 a.m. - 4:30 p.m.
Wednesday	7:30 a.m. - 4:30 p.m.
Thursday	7:30 a.m. - 4:00 p.m.
Poster Presentations:	
Tuesday	8:30 a.m. - 5:30 p.m.
Wednesday	8:30 a.m. - 5:30 p.m.
Receptions	
Tuesday	4:30 p.m. - 6:00 p.m.
Wednesday	4:30 p.m. - 6:00 p.m.
Deli Lunch:	
All Three Days	11:45 a.m. - 1:30 p.m.

Clinical Poster Presentations

Tuesday and Wednesday, November 7 & 8
8:30 a.m. to 5:30 p.m.
Main Corridor, Regency Ballroom

Poster displays will be set up beginning at 8:30 a.m., November 7 and 8. Authors will be available to discuss their posters during all refreshment and luncheon breaks both days.

Adolescent Hypertension: Biochemical, Physiological and Hormonal Abnormalities
Alan B. Gruskin, MD, Children's Hospital of Michigan

Allogenic Whole Pancreas Transplantation in Insulin Dependent Diabetes Mellitus
Heung K. Oh, MD; J. Goldman, MD; M. Webb, MD; M. Mozes, MD; N. Turza, MD; W. Kupin, MD and K. Venkat, MD, Henry Ford Hospital

Auditory Brainstem Response (ABR) Changes with Chronic Perilymph Fistula in the Cat: Preliminary Report
S.A. Bhansali, MD; J. Benitez, MD and S.P. Cass, MD, Wayne State University School of Medicine

Cachectin/Tumor Necrosis Factor: A Possible Mediator of Cancer Anorexia in the Rat
Mark C. Stovroff, MD, University of Michigan Medical School

Capnography Determinations of Arterial-Alveolar Gradients of Carbon Dioxide: Positive Correlation with Mean Airway Pressure
Daniel Billman, MD; Joanne Nicks, RRT and Robert Schumacher, MD, University of Michigan Medical School

Dementias 1989: Imaging Evaluation
J. Seitz, MD and Conrad Nagle, MD, William Beaumont Hospital, Royal Oak

End Tidal CO_2 Measurement in the Detection of Esophageal Intubation During Cardiac Arrest
Assaad J. Sayah, MD, William Beaumont Hospital, Royal Oak

Epidural Anesthesia is Superior to Spinal or General for Outpatient Knee Arthroscopy
G.I. Randel, MD; L. Levy, MD, S.P. Kothary, MD; M. Brousseau, CRNA and S.K. Pandit, MD, University of Michigan Medical School

Evaluation and Management of Patients with Lupus Anticoagulant Detected on Preoperative Screening
Sundara B.K. Raman, MD and Maria Sawdyk, MD, Henry Ford Hospital

Imaging for Follow-up of Head and Neck Cancer Patients
Jaroslaw Muz, MD; Robert H. Mathog, MD; Lawrence P. Davis, MD and George A. Kling, MD, Wayne State University School of Medicine

Necrotizing Fasciitis: Problems & Progress
Andrew Saxe, MD and William Reynolds, DDS, MD, Sinai Hospital of Detroit

Optimal Method for Preoperative Localization of Parathyroid Adenoma
Antonio G. Balingit, MD; William Beierwaltes, MD; John E. Frietas, MD and Conrad E. Nagle, MD, William Beaumont Hospital, Royal Oak

Pseudoaneurysm of the Abdominal Aorta Associated with Blunt Abdominal Trauma
Richard Potts, DO; Gary Ferenchick, MD and Patrick Alguire, MD, Michigan State University College of Human Medicine

Pulmonary Hemorrhage Masquerading as a Severe Pneumonia in a Pancytopenic Patient
Denise A. Hastings, MD and Kenneth Schwartz, MD, Michigan State University College of Human Medicine

Heredity Elliptocytosis Masquerading as Mononucleosis-Associated Hemolytic Anemia
Patricia Bozung, MD, and John Penner, MD, FACP, Michigan State University College of Human Medicine

Sweet's Syndrome: A Cutaneous Manifestation of Internal Malignancy
Stephen Lemon, MD; Rebecca Beyth, MD; Gary Ferenchick, MD and Barbara Mathes, MD, Michigan State University College of Human Medicine

Tanning Parlors: The Acceleration of a Cancer Epidemic?
Rebecca Beyth, MD; Melinda Hunnicutt, MD and Patrick AlguireMD, FACP, Michigan State University College of Human Medicine

Tissue Ferritin Levels as an Independent Tumor Marker in Early Stages of Breast Cancer
Joseph R. Ferrari, MD; Robert E. Weinstein, MD; Catherine A. Lobocki, MT and David R. Pieper, PhD, Providence Hospital

Treatment of Life Threatening Status Asthmaticus with Isoflurane
L. Hennessey, MD; S. Guertin, MD and R. Honicky, MD, Michigan State University College of Human Medicine

Which Volatile Anesthetic for Outpatient Anesthesia? Quality and Speed of Recovery
S.K. Pandit, MD; L. Levy, MD; G.I. Randel, MD and S.P. Kothary, MD, University of Michigan Medical School

1989 MSMS ANNUAL SCIENTIFIC MEETING
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Hyatt Regency, Dearborn

Registration Form

Name ____
(Please print) (first) (intial) (last)

Street ____

City ______________________ State ________ Zip __________

County ____________________ Phone (   ) ______________

MSMS Member: Yes☐ No☐ Resident ☐ Specialty __________ Other ________

Physicians must make their own hotel reservations prior to 10/12/89 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

CHOOSING YOUR COURSES

Please check the courses you wish to attend. In each case, **please indicate a second choice** should the first already be filled. Maximum attendance figures have been set for each course, depending on room size.

Tuesday Morning, November 7

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Assessment and Treatment of Depressive Disorders
___ Basic Cardiac Life Support
___ Congestive Heart Failure: Update on Diagnosis & Treatment
___ Critical Care: Practical Points for the Primary Care Physician
___ Current Status of Magnetic Resonance Imaging and Spectroscopy
___ Industry & The Environment
___ Pain and Symptom Control for Patients with Advanced or Terminal Cancer
___ Review of Ear Problems
___ The New Arthritides

Wednesday, November 8

(7:15 - 8:15 AM, *No Fee*)

___ "Early Bird" Plenary Session on Drug Abuse (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Antimicrobial Therapy
___ Basic Cardiac Life Support
___ Emergency Management of Poisonings and Overdoses
___ Hypercholesterolemia: From Eight to Eighty
___ Methods and Ethics of New Reproductive Technologies
___ Primary Care for Women
___ Screening & Prevention in Adolescent Patients
___ Sleep Disorders in Primary Care Medicine
___ The Accidental Geriatrician

Thursday, November 9

(7:15 - 8:15 AM, *No Fee*)

___ "Early Bird" Plenary Session on Hepatitis B (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Acute MI from ER and Beyond
___ Basic Cardiac Life Support
___ Common ENT Problems in Children
___ Falls in the Elderly
___ Leg and/or Back Pain and Dysfunction: Diagnosis and Management
___ New Neurology - The Common and The Uncommon
___ Priorities In Maxillofacial Reconstruction
___ The Spectrum of Ulcer Disease - 1989
___ Trauma Education Programs for Primary Care Physicians

A deli sandwich will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ☐ Wednesday lunch ☐ Thursday lunch ☐

Tuesday Afternoon, November 7

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Breast Cancer: Diagnosis and Management
___ Care of the Medical/Social High-Risk Patient: Newborn to Infant
___ Childhood Depression: A Family Affair
___ Gastrointestinal Surgery for the Non-Surgeon
___ Managing Difficult Physician-Patient Relationships
___ Orthopaedics in Family Practice
___ Perioperative Risk Management in Surgery and Obstetrics
___ Safe Weight Loss
___ The Eye as a Window to Systemic Disease
___ Update on Ethics: Three Current Concerns

Wednesday Afternoon, November 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Allergy and Asthma Update: 1989
___ Colorectal Cancer - The Silent Epidemic
___ Dermatology: Melanoma 1989
___ Fertility and Pregnancy at 35-Plus: Is it Different?
___ Is My Environment Making Me Sick, Doctor?
___ Optimizing Thyroid Disease Diagnosis
___ Radiology for Clinicians
___ Sexuality and Sexual Problems
___ The Aging Gut
___ What's New in Urology

Thursday Afternoon, November 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

___ Brain and Heart: 1989
___ Clinical & Research Studies in Common Plastic Surgery Problems
___ Current Concepts in the Management of Electrolyte and Acid Base Problems
___ Management of Your Patient on Workers Compensation
___ Psychoactive Drug Use & Misuse: A Psychiatric/Medical Controversy
___ The HIV Positive Patient: Symptoms, Care and Treatments
___ Violence Within Families
___ Wiping Out Sinus Disease: The Sequel

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Multiply total number of half-day courses by appropriate fee:

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____ x $15 (retired) = $____
____ x $70 (non-members) = $____
____ x $15 (residents) = $____
____ x $0 (students) = $____
____ x $10 (student lunch) = $____
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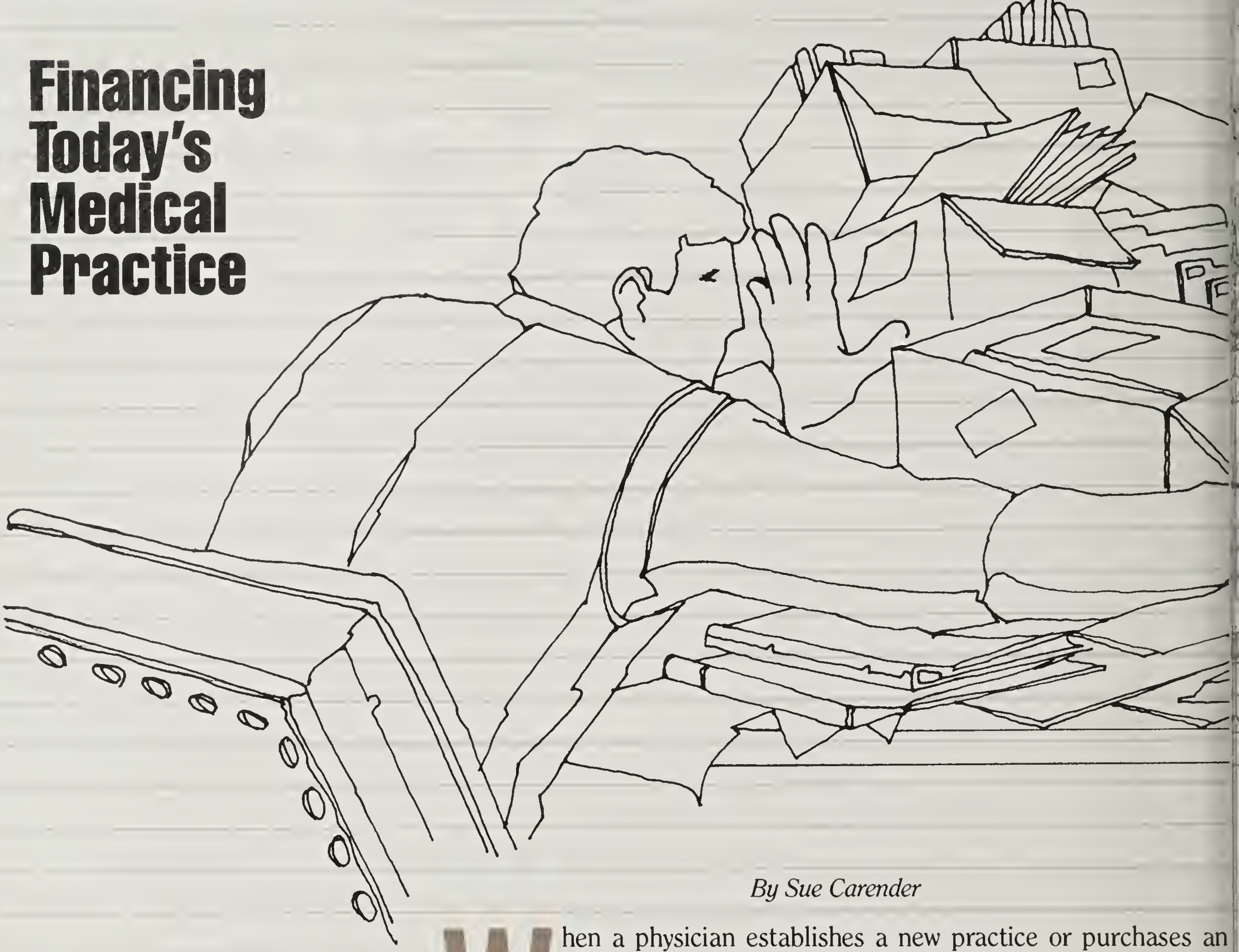
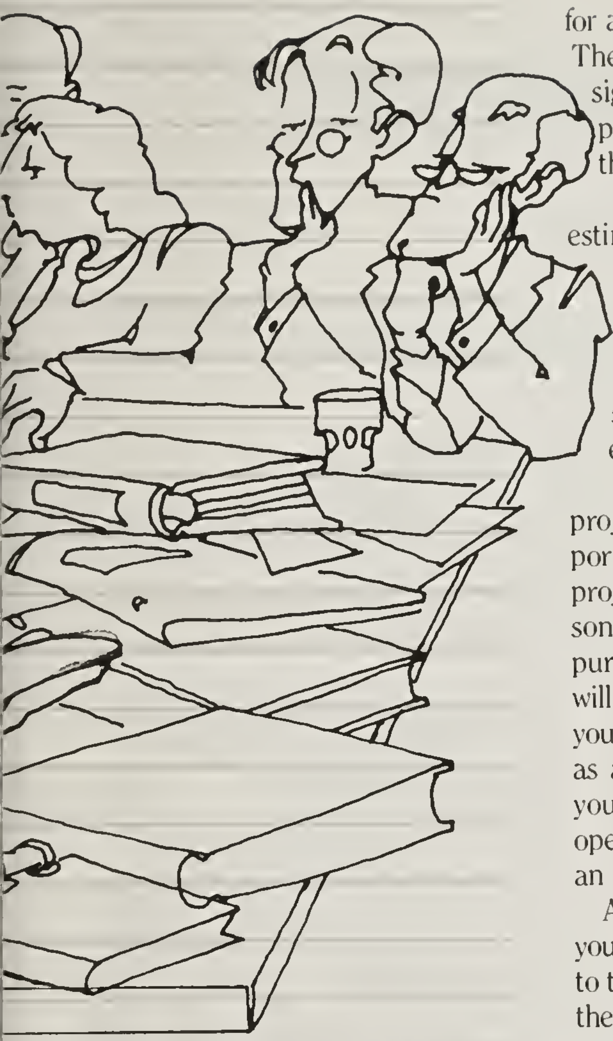


By Sue Carender

When a physician establishes a new practice or purchases an existing one, a number of tasks must be accomplished to get the new practice operating smoothly. One of the most important of these is obtaining financing for the equipment and working capital of the practice. While funding may be available from finance companies, the leasing divisions of equipment companies or private sources, this article will deal with the relationship between the physician and a commercial bank in establishing the financial groundwork for the new practice.

Not long ago, a physician could simply sign his name and get all the bank financing needed to start or purchase a practice. Today, financing arrangements have changed almost as dramatically as the environment in the health care field. Banks now tend to view a physician as operating a business, and look to him not only to perform medical procedures, but also to ensure that the business is properly managed. The physician's capability in managing his practice is one of the key ingredients used by a lender in evaluating and granting a loan for a practice start-up or buy-out.

Since the physician's success is the lender's basis for the loan repayment, he is interested in seeing that the physician does well from the start. Because of this concern, a lender will normally ask you for information on many different aspects of both your personal and business plans, to allow him to become totally familiar with your situation. Your lender can play an important role in the development of your practice, just as your attorney and accountant will, but he can only do an effective job for you if he has all the facts. This is the reason he may ask for what you might consider a great deal of information.



Preparing your information

There are four primary areas of information a lender will examine: (1) personal background information; (2) a personal financial statement; (3) proposed equipment/furniture/leasehold improvements; and (4) cash flow projections.

Personal Background Information. This includes summary information of your education, previous work experience as either an associate or principal in a practice, a description of your professional licenses, and a list of personal references. If you are working with the bank for the first time, the personal background information is especially important in establishing your relationship. The more your lender knows about you and your practice, the better he will be able to assist you.

Personal Financial Statement. This is a "snapshot" of your financial situation at a point in time. It includes monetary information on your assets, liabilities and income. Your lender also may ask for one or more years of recent personal income tax returns.

Building/Furniture/Equipment/Leasehold Improvements. Your lender will need a copy of your purchase or lease agreement. If you are purchasing an existing structure or constructing a new building, the bank also will require an appraisal of the building or of the construction plans and site. The medical supply company you deal with can provide invoices for any medical equipment you purchase. The contractor or architect you use to design or modify your office space can provide an outline and description of the work to be done.

Cash Flow Projections. These are estimates of how much cash will be coming into your practice (from income and loan proceeds) and how much will go out (for expenses and capital equipment). At the same time, you should consider what your base living expenses will be.

Of these four items, the cash flow projections are the most valuable. It is important to spend the time to develop your projections and have them based on reasonable assumptions, both for the lender's purposes and for your own. The lender will utilize those numbers in evaluating your loan request, but can use them also as a cash flow budget in evaluating how your practice is progressing once you open your doors. In that sense, it becomes an excellent management tool for you.

Aside from the financial information you present, you should try to sell yourself to the lender. In a start-up practice, where the primary asset is you (and your abilities as a physician), your character plays an important role in the lender's decision. The planning you go through for the new practice, plus the completeness of the financial information you provide, will be a major factor in a lender looking favorably on your request.

Requesting the loan

Once you have prepared this information, you are ready to make your loan request. Remember that the purchase of equipment may be only part of the money you will need to get your practice started.

One of the other areas you may borrow money for is leasehold improvements. These are the structural modifications to your office space made by a builder that will conform it to your needs in operating your practice. While some medical specialties may not need as much, leasehold improvements may be a substantial part of the total financial package.

The second area is working capital. This includes money for office rent and utilities, staff salaries, supplies, insurance, and taxes.

The third area is for money to furnish your front office and waiting areas with such things as desks, chairs, and cabinets.

Loan options

Lenders generally will offer a number of alternatives for financing a new practice, and generally the deal can be structured according to your needs. In many cases, however, the choices available to you depend on your background, experience, and financial resources.

Today, unsecured loans backed only by the good faith credit of the borrower are not generally offered to medical start-up practices. A more common arrangement is for the lender to offer a secured loan. Here, physical assets such as the equipment, furniture, or personal assets of the borrower are asked to be pledged to the bank as collateral for the loan. Should the practice not succeed, the lender would then look to the proceeds from the sale of the pledged assets as the repayment source for the loan. A pledge of accounts receivable also may be required.

In some cases, it may be necessary to have a cosigner on the note, whether secured or unsecured. Normally a friend, relative or business associate will sign. In effect, the cosigner guarantees that if the original borrower cannot repay the loan, the cosigner will repay the debt.

Loan terms

A primary concern of a physician attempting to establish and finance a medical practice is what loan terms the lender will offer. These terms include the repayment schedule and the interest rate.

The repayment schedule can be from three to seven years depending upon the practice's cash flow.

The borrower has two alternatives as to interest rate. The first is a floating rate, which is based on the bank's prime lending rate, which may change from time to time. The second alternative is a fixed rate loan, which is set on the date of closing, based on the lender's cost of funds on that day. A fixed rate may be slightly higher than a floating rate, but the borrower has the security of knowing that the rate and payment amount will remain the same over the life of the loan.

The important thing to remember in making your loan request is that your lender can work most effectively with you if you provide the most complete, accurate information possible. A total banking relationship with the lending institution also can prove helpful. This means having business and personal bank accounts, personal credit, and pension/IRA plans with the lending institution. This total relationship can provide many opportunities for your banker to be a useful resource for operating and further developing your practice. ■

The author is market manager, Health Care Professionals, for Comerica Bank. Comerica, endorsed by MSMS for its Merchant Credit Card Program, has sponsored several conferences for the MSMS Young Physicians Section.

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An Insatiable Desire For Work Makes Robert J. Sokol, MD One Busy Dean

By Judith E. Marr, Editor

Wayne State University School of Medicine Dean Robert J. Sokol, MD, knew he wanted to locate in Detroit "when I came here the third time and decided I really liked the tire."

That was in 1983, when the Rochester, NY, native accepted the chairmanship of the WSU Department of Obstetrics/Gynecology. He arrived after holding posts in St. Louis, MO and Cleveland.

The tire, of course, is the giant Uniroyal advertisement along I-94 on the southern outskirts of Detroit.

"I tell everybody that's our Eiffel Tower," Doctor Sokol says with a grin. The energetic, dark-haired dean's observations are full of humorous asides.

The state has further attractions for Doctor Sokol. He likes to camp in northern Michigan, and he finds Detroit has a distinct personality.

"Detroit started as a fur trading post and it's still a little rough and tumble. That suits the way I think," he says. "Detroit does things. My wife and I have never lived anywhere we liked better."

Doctor Sokol was named WSU School of Medicine dean in April, after serving nearly a year as interim dean following the departure of Henry Nadler, MD.

By his own admission, Dean Sokol likes to talk. He also says he likes to get things done. The two traits appear to be a good combination for his job.

"I *wanted* this job," he says. "I think there's a real opportunity here, even in fiscally difficult times, to continue to move the school forward and in the right directions.

"The previous dean did an outstanding job of upgrading the academic performance of this school. I think it is a better school now by a considerable margin than it was six to seven years ago. And it was a pretty good school then."

Plans for improvements

Doctor Sokol plans to focus improvements in the following areas, building on the school's areas of strength:

1) **Oncology.** Dean Sokol is cooperating in preparation of a multi-million dollar proposal to expand the oncology program at WSU and the Detroit Medical Center, in conjunction with the Michigan Cancer Foundation. WSU already serves as one of the country's 20 designated Comprehensive Cancer Centers. Doctor Sokol plans to coordinate clinical science approaches to preventing, diagnosing and treating cancer, and to boost the medical school's basic science areas which support cancer research.

2) **Neuroscience.** A faculty committee is taking a critical look at ways to boost the collaboration between the clinical and basic sciences in this area.

3) **Curriculum.** Administration and faculty are evaluating curriculum changes made two years ago. They also are looking at alternatives in accelerated and decelerated degree programs.

On a larger scale, Doctor Sokol speaks very enthusiastically of the strategic planning process underway in both the medical school and the affiliated Detroit Medical Center.

"The 'medical education business' is changing very rapidly," he acknowledges. "But we need to take the time to look at our problems."

Resources a constant need

Obtaining resources — money and people — is a constant challenge for the medical school dean.

"The days when someone just handed you money unfortunately are over," says Doctor Sokol. He's fond of the quote, "The ivory tower has become a walk-in clinic," and points out, however, that the medical school has to have the resources to carry out such a role.

Should Wayne State University School of Medicine alums or other interested Michigan physicians wish to donate money to the medical school, Doctor Sokol has specific suggestions.

1) Scholarships. "I would love to have a minimum of 25 full-tuition, four-year scholarships," says the Dean. "Medical school, even in Michigan, is tremendously expensive."

Wayne State students tend to be more non-traditional, he says, and to have more limited resources. "To be competitive for the best students, we need a scholarship program."

This fall, 10 students will enter the medical school on such newly-created scholarships. Doctor Sokol would like to see this program expanded.

2) Basic Sciences. This one is harder to sell, admits Doctor Sokol, but he says increased support for facilities, equipment and faculty to teach the basics is crucial.

"We could surely use help for this program. If anybody wants to help we'd be delighted."

Actual public dollars coming to medical schools have constricted considerably over the last decade, particularly when you take inflation into consideration, he says.

"We need private support even more perhaps than the private institutions," he says. "Our vision for the school says we can and should be better than we are now, but it takes resources."

Other important WSU Medical School programs where alumni and other physicians' support could be directed, says Doctor Sokol, include the Kresge Eye Institute, Children's Hospital, and the Cancer Institute.

WSU's mission

A major part of the WSU Medical School mission is to train physicians to take care of Michigan citizens, says Doctor Sokol. "It's clear to me this is a facility of the state," he says.

He sees no decline ahead in numbers of students enrolled. WSU plans to have more than 1,000 medical students enrolled for the 1989-90 academic year.

"We have about the same number of applicants this year as last, and the quality is the same. There is good evidence we really have a shortage of physicians in many areas of the state." He attributes this to a number of reasons, "liability problems not the least of them."

Michigan for years has been a physician-exporting state, he points out. "We are not long on doctors. We surely are not experiencing the predicted 'physician glut.'"

He is proud of Wayne's role in training physicians.

"This is a good medical school. At one time or another a high proportion of the physicians across the state, certainly in the southeast Michigan area, have trained here. I think we do a good job.

Dean Sokol is especially proud of the community service Wayne State medical students provide.

"I am truly impressed," he says. "They have a tremendous public service commitment. Our students take that seriously. They are our best ambassadors."

Doctor Sokol seems to relish his deanship. The average dean, he said, holds the position two years. "I intend to be here longer. I am lining up the projects serially — there is so much to do."

An insatiable desire for work

He seems to have an insatiable desire for work. His single-spaced curriculum vitae stretches nearly 50 pages, and includes nearly 35 pages of published works.

He has a hospital telephone line connection at home, and says he works 20 hours a day.

"I probably will take some getting used to. Everyone is willing to work with me, and I would hope that can continue for a long time. I would like to see working relationships amongst the dean's office, faculty and medical center improve. That will take some doing."

He seems more than ready for the "doing."

"I said at the beginning of the interim deanship that I'm a rotten gardener. I'm not good at sitting back and just watching things grow. Got a problem? I try to get in and get it taken care of."

Doctor Sokol has a number of clinical and medical care concerns.

"I teach, I see patients, I have served on millions of committees. But my basic identity — how I think of myself — is as a professor, a scientist."

His longtime theme has been the prevention of brain damage. Over the past decade he has been working in the area of prenatal drug use, including alcohol.

He is director of the Fetal Alcohol Research Center at Wayne, established last year with a $5 million grant from the National Institutes of Alcohol Abuse and Alcoholism.

He is concerned with the problems of infant mortality, care of the medically indigent, and the general problems of the aging.

"I'd like to see fewer babies die, more healthy people, more people truly develop to their potential," he says.

"If I had my way, and unlimited resources, I have all kinds of neat ideas for things I'd love to see happen," he says.

"But I think we do extraordinarily well here at Wayne. In a time of limited resources, one has to pick and choose.

"That's tough. I can't accomplish what I want to in just two years. I have every intention of being here a good long time." ■

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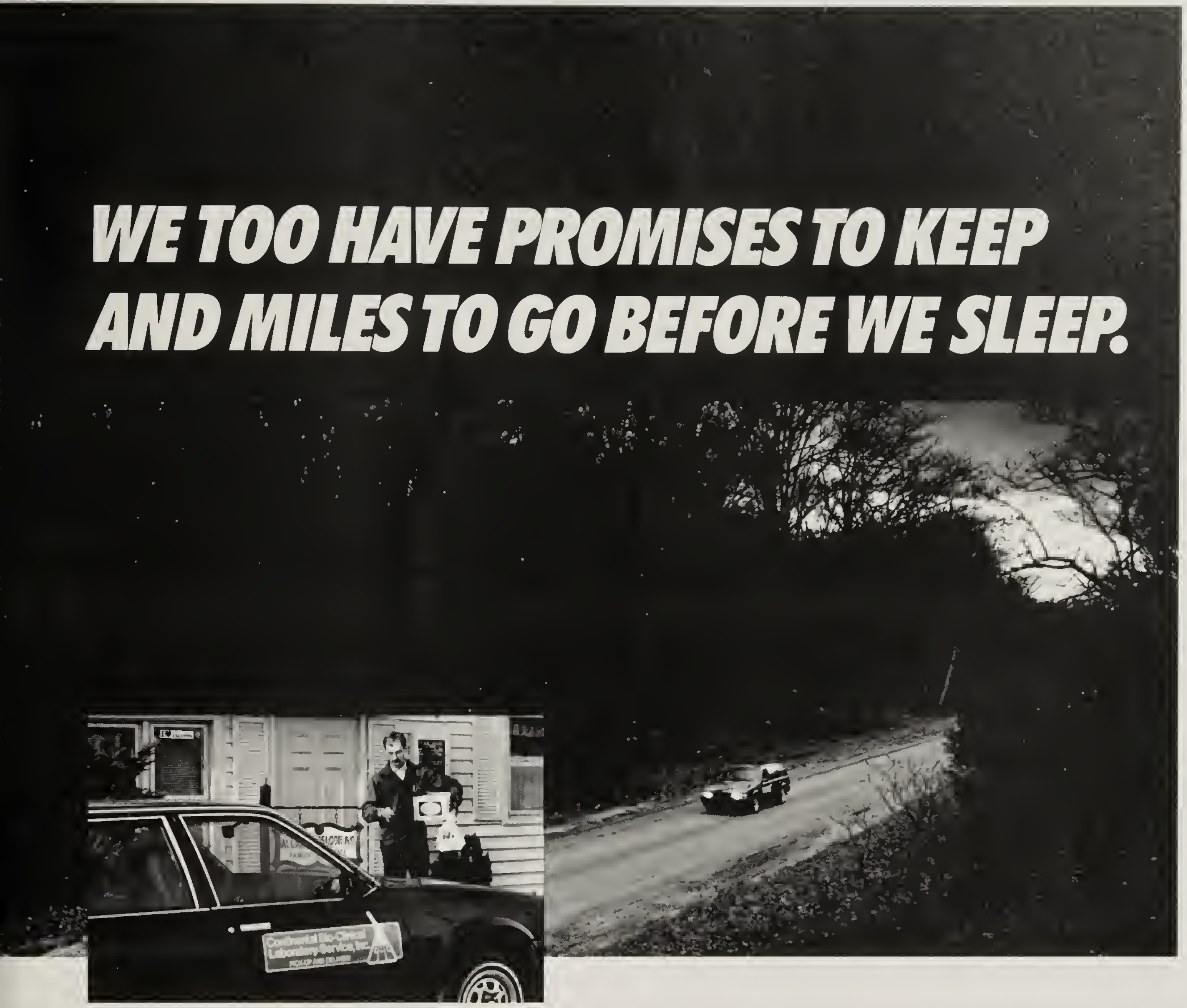
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Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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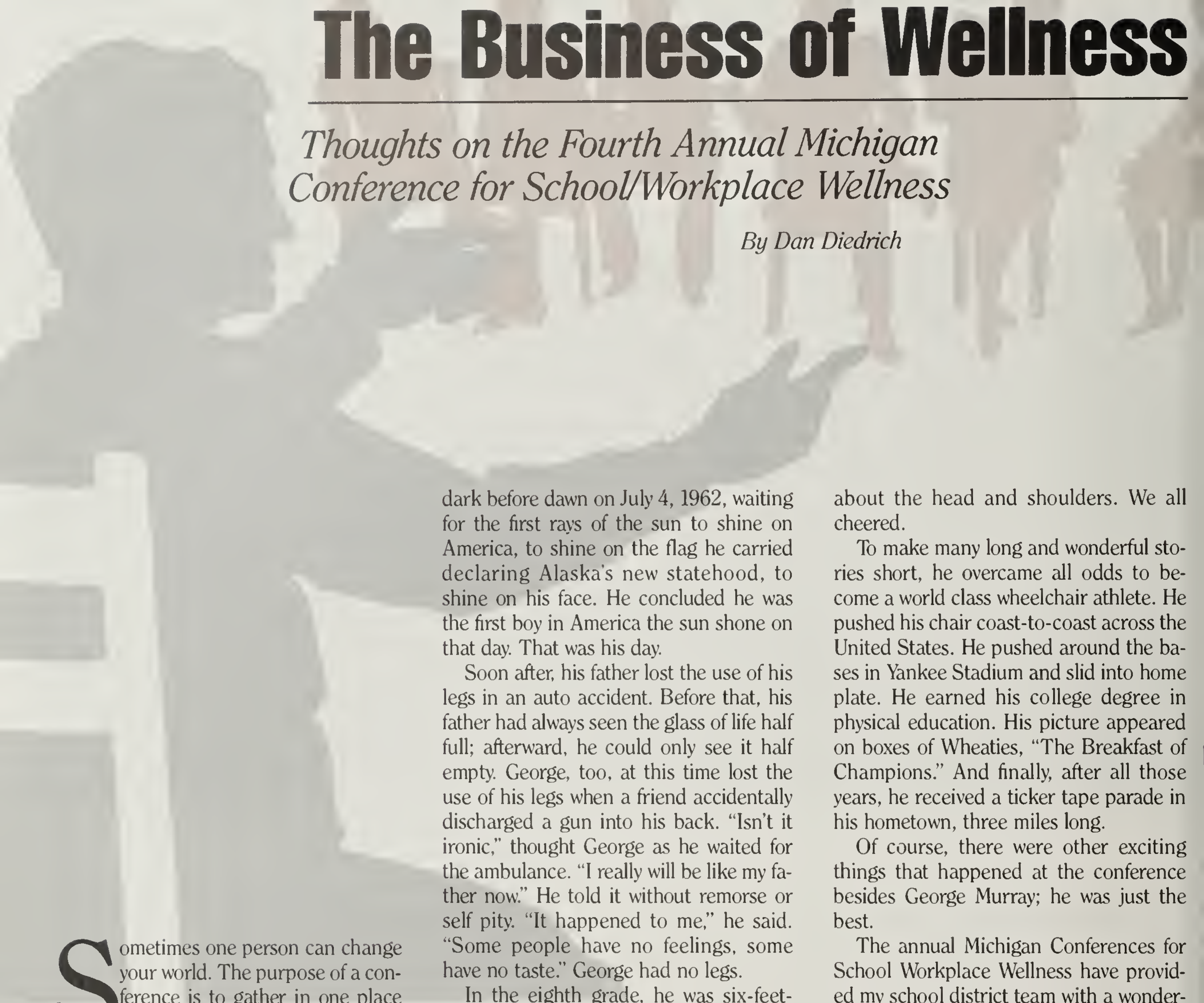


The Business of Wellness

Thoughts on the Fourth Annual Michigan Conference for School/Workplace Wellness

By Dan Diedrich

Sometimes one person can change your world. The purpose of a conference is to gather in one place people who can change the world and are willing to be changed by a new vision. Sometimes one person can change the way you look at the world for the rest of your life.

George Murray sat in a chair at the 4th Annual Michigan School/Workplace Wellness Conference and told stories for two hours. (The School/Workplace Wellness Conference, which MSMS has been instrumental in developing, has been the catalyst for many school-based wellness programs in the past four years.) George employed no fancy overheads, no charts, no computer graphics, no high power promotional tactics. He just sat and told stories. The room was packed. Everyone listened. Everyone changed.

There was the story of his youth in the woods of Maine, hunting and fishing. He called himself the best-equipped boy scout in New England. Just like his father, he wanted to be a true native American. At the age of 13, he led an expedition of scouts to the top of a mountain near the coast of Maine. George sat in the frigid dark before dawn on July 4, 1962, waiting for the first rays of the sun to shine on America, to shine on the flag he carried declaring Alaska's new statehood, to shine on his face. He concluded he was the first boy in America the sun shone on that day. That was his day.

Soon after, his father lost the use of his legs in an auto accident. Before that, his father had always seen the glass of life half full; afterward, he could only see it half empty. George, too, at this time lost the use of his legs when a friend accidentally discharged a gun into his back. "Isn't it ironic," thought George as he waited for the ambulance. "I really will be like my father now." He told it without remorse or self pity. "It happened to me," he said. "Some people have no feelings, some have no taste." George had no legs.

In the eighth grade, he was six-feet-three-inches tall and couldn't wait to play high school basketball. Then the accident happened, and he had to watch his friends go undefeated four straight years and win the state championship. George sat on the curb and watched them enjoy a three-mile ticker tape parade.

In college, he was denied the opportunity to major in physical education and subsequently, spent hours in the pool hall and in front of a punching bag honing a couple of upper body skills. One evening, one of the local pool sharks made the mistake of claiming the quarter on the table that reserved the next game for George. George sat up for his rights and was told by the bully that he'd be kicked around the room if he wasn't sitting in that chair. George shot back, "If that's the only thing holding you back, I've got another wheel chair in the trunk of my car. Let's go out in the parking lot and settle this." The entire pool hall emptied out and after suffering the initial unschooled onslaught of his newly-impaired challenger, George commenced to giving him a liberal education about the head and shoulders. We all cheered.

To make many long and wonderful stories short, he overcame all odds to become a world class wheelchair athlete. He pushed his chair coast-to-coast across the United States. He pushed around the bases in Yankee Stadium and slid into home plate. He earned his college degree in physical education. His picture appeared on boxes of Wheaties, "The Breakfast of Champions." And finally, after all those years, he received a ticker tape parade in his hometown, three miles long.

Of course, there were other exciting things that happened at the conference besides George Murray; he was just the best.

The annual Michigan Conferences for School Workplace Wellness have provided my school district team with a wonderful opportunity to rest and reconnoiter, to share and show off, to plan and prognosticate. And at this year's conference, we did them all. Wyoming Public Schools has been involved in the business of wellness for five years. With the cooperation, assistance and participation of our school board and administration, we have put together an exemplary program which includes health screening, newsletters, pentathlons, smoking clinics, aerobics, walks and an employee assistance program. At this year's conference, we were asked to show off. Our team ran a workshop describing our accomplishments.

But we also came to be changed and encountered much useful information and material from other presenters. Our Wyoming Wellness group has targeted no-impact exercises and stress reducing strategies for employees on the margins of beginning a health program. The conference provided us with not only the pertinent information in these areas, but also with hands-on learning experiences. Aquatic exercises took place in the pool.

During *Knead a Friend*, we actually did knead a friend. And appropriate sounds issued from the *Self Defense Exercise Seminar.* The technique was taught in addition to the theory.

On site, Sugerloaf provided the conference participants with ample opportunity to practice what they preached. And we never lacked company on athletic adventures. Personally, I played tennis with someone from Bloomfield Hills, golfed with someone from Marquette, ran with someone from Mt. Pleasant, and danced with someone from Detroit.

Finally, the accessibility of the conference organizers and sponsors lent a sense of credibility and importance to the event, particularly Deborah Zannoth, of the Michigan State Medical Society, and Jane Wagner, of the Michigan Dairy Council. Thanks for your efforts (and the "birdie dance" on number nine at the golf tournament). See you next year! ■

Dan Diedrich is director of Horizons, a public alternative high school established in 1978 in Wyoming, Michigan, for students 16 to 19 years old.

Wellness in Elementary Schools

By Marvin Robertson

It pays to find ways to stay well.

Have doubts? Then listen to this. Over the past three years, 62 elementary schools across Michigan have shared $46,950 in prize money for simply finding ways to stay well.

Even better, the money is only one of the benefits derived by those schools and hundreds of others that have participated in a rather unique competition where there are no losers.

Birth of the wellness competition

It all started in the spring of 1986. Comerica Incorporated, a leading Michigan bank holding company, in cooperation with the Mental Health Association of Michigan, started looking for ways to expand a very successful, but somewhat limited, program designed to build self-esteem and problem-solving skills in elementary school children.

The self-esteem/problem-solving program, about three years running, was offered to one school district each year. Comerica provided the curriculum, all materials, training for teachers, and support for classroom implementation. The program was received with enthusiasm in Muskegon, Detroit, and the Jackson school districts, but the sponsors wanted to add a new dimension. It was then that they decided to sponsor a wellness competition to every public elementary school in Michigan.

The rules formulated for the competition require emphasis on mental wellness as well as physical wellness. Schools are sent an application/enrollment form and are invited to enter the competition. Once they do, they are sent wellness posters, wellness newsletters, theme bookmarks, and other materials designed to generate enthusiasm and stimulate activities. Schools are urged to document their activities and to submit a summary of their program for evaluation near the end of the school year.

Since the competition began three years ago, approximately 5,800 teachers, 150,000 students, and 400 schools have been involved.

Judging for the 1988-89 competition took place at the Michigan State Medical Society headquarters in East Lansing. The judges, all involved in the fields of health and education, were: Loren Bensley, PhD, Department of Education, Central Michigan University; Barbara Hower, Michigan Department of Education; Richard Murdock, president, Michigan School Health Association and health planning consultant, Office of Health and Medical Affairs, Michigan Department of Management and Budget; and Deborah Zannoth, chief, Membership Development, Michigan State Medical Society.

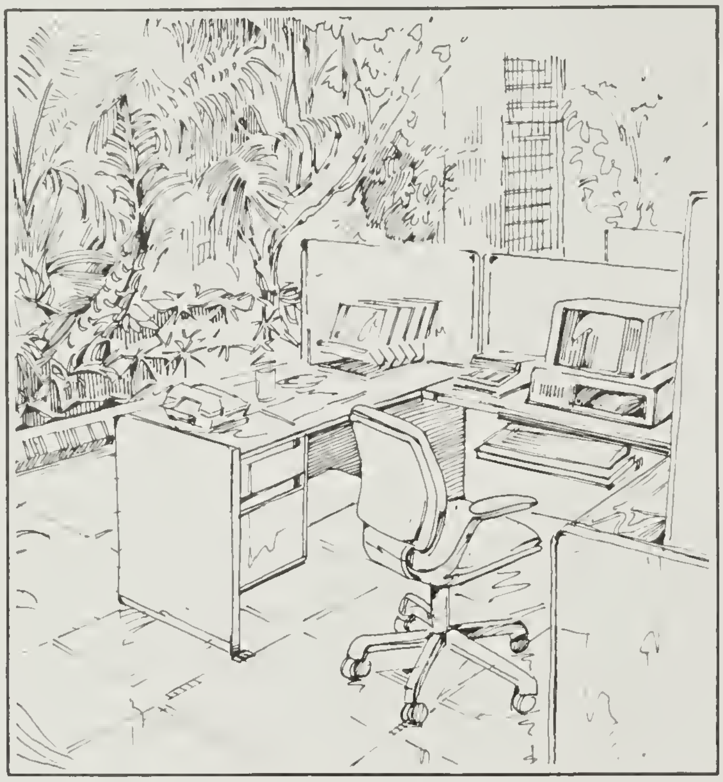
At the end of this year's evaluation process, the judges were deadlocked when it came to picking a first place winner. Two schools' programs were so close in quality that the judges felt both should receive the top award. They presented their dilemma to the sponsors and the decision was made to award first place to both schools. Because the top award was $5,000, the decision was not reached lightly. Thus, Lakeview Elementary in Negaunee and Northwestern Elementary in Eaton Rapids each received $5,000 to continue or expand their wellness activities. Ironically, those schools had finished second and third, respectively, in the 1987-88 competition.

In addition to the two first place awards this year, there was a $3,000 second place award, a $2,000 third place award, a $1,000 fourth place award, and 15 $250 honorable mentions.

The following is a sampling of the activities undertaken by the top five winning schools: wellness trivia games that require students to utilize research skills to produce correct answers; securing a mobile mammograph service to test female staff employees and family members (for breast cancer); developing a "House of History" where students assumed the role, in wax museum style, of famous people they had researched; and a "Let's Get Caught Being Good" program to reinforce positive behavior school-wide.

As indicated earlier, only 62 schools have shared in the monetary awards since the competition began. Yet, each year the schools who were not among the winners have been unanimous in praising the competition's concept and have indicated what a valuable tool it has been in improving the well-being of their students, their staffs, parents, and the community at large. They say it, indeed has been a competition where every participant is a winner. ■

Marvin Robertson is corporate communications officer for Comerica Bank and has been actively involved in the design and implementation of the "CHOICES" competition. In addition, he has been an active participant at the Michigan Annual School Worksite Wellness Conferences.



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DEATHS

George W. Bennett, MD
Elsie

George W. Bennett, MD, anesthesiologist, died July 6. He was 82. Doctor Bennett earned his medical degree from the University of Michigan in 1933 and began his practice in 1934. He served as an anesthesiologist/staff member at Owosso Memorial Hospital and Clinton Memorial Hospital. Doctor Bennett also was the medical director of Ovid Convalescent Manor. He gave 50 years of service to the Elsie community as a medical doctor. He also was an active member in the American Medical Association and Michigan State Medical Society.

Richard M. Berg, MD
Port Huron

Richard M. Berg, MD, radiologist, died July 30. He was 64. Doctor Berg received his medical degree from the University of Iowa. He later served on staff at Mercy, Port Huron and River District hospitals. Doctor Berg was a member of the American Medical Association, the Michigan State Medical Society, the Oakland County Medical Society, the American Cancer Society, and the American College of Radiology.

Richard C. Connelly, MD
Grosse Pointe

Richard C. Connelly, MD, internal medicine and gastroenterology specialist, died August 13. He was 89. Doctor Connelly was president and founder of the first medical staff at Bon Secours Hospital and was a local physician for more than 50 years. A former president of the Detroit Medical Club, Doctor Connelly was a member of the following organizations: American Medical Association, Michigan State Medical Society, Wayne County Medical Society, Detroit Gastroenterological Society, Michigan Association for Medical Information, Association for Hospital Medical Education, and American Medical Writers Association.

Harold L. Daly, MD
Albion

Harold L. Daly, MD, general surgeon, died July 2. He was 65. Doctor Daly was a 1950 graduate of University of Maryland School of Medicine. He served his residency at the Lutheran Hospital in Baltimore. Doctor Daly was on the medical staff of Albion Community Hospital and later began a private practice with his wife, Doctor Miriam Daly. Most recently he was a staff member of the Eaton Rapids Community Hospital and the Hayes-Green Beech Hospital. Doctor Daly was a member of the American Medical Association, Michigan State Medical Society, Calhoun County Medical Society, and the American College of Surgeons.

Robert J. Fraser, MD
Coldwater

Robert J. Fraser, MD, a retired Branch County abdominal surgeon, died July 22. He was 80. Doctor Fraser received his medical degree from Indiana University School of Medicine in 1934. He began his practice in Bronson in 1935 and moved it to Coldwater in 1939, where he practiced until 1968. Doctor Fraser then went on to become chief of staff at the Coldwater State Home and Training Center, retiring there in 1975. He was honored in 1985 by the Michigan State Medical Society for 50 years of practicing medicine.

John Teshima, MD
Southfield

John Teshima, MD, retired obstetrician-gynecologist, Highland Park General Hospital, died June 29. He was a 1941 graduate of California-San Francisco Medical School. Doctor Teshima served as a lieutenant colonel in the Air Force Medical Corps during WWII. He then practiced medicine in the Detroit area for about 30 years before retiring in 1982. He was on staff at Detroit General, Harper, Beaumont, and Hutzel hospitals and had been an associate professor at the Wayne State University Medical School.

Samuel Trupiano, MD
St. Clair Shores

Samuel Trupiano, MD, an otorhinolaryngologist, died July 27. He was 67. Doctor Trupiano graduated from Wayne State University in 1951. He was a physician on staff at Bon Secours Hospital, Grand Rapids; St. John's Hospital, Detroit; and Holy Cross Hospital, Detroit. Doctor Trupiano was a member of the Wayne County Medical Society and the Michigan State Medical Society.

Keith S. Wemmer, MD
Battle Creek

Keith S. Wemmer, MD, a retired family practitioner, died August 3. He was 67. Doctor Wemmer received his medical degree from Ohio State University in 1946. He served as an Army Medical Corps captain from 1947-1949 and completed his medical internship at Blodgett Memorial Hospital in Grand Rapids. In 1953, Doctor Wemmer came to Battle Creek from Ohio and began his family practice. He served as president of the Calhoun County Medical Society in 1972 and as chief-of-staff at Leila Hospital in 1978-1979.

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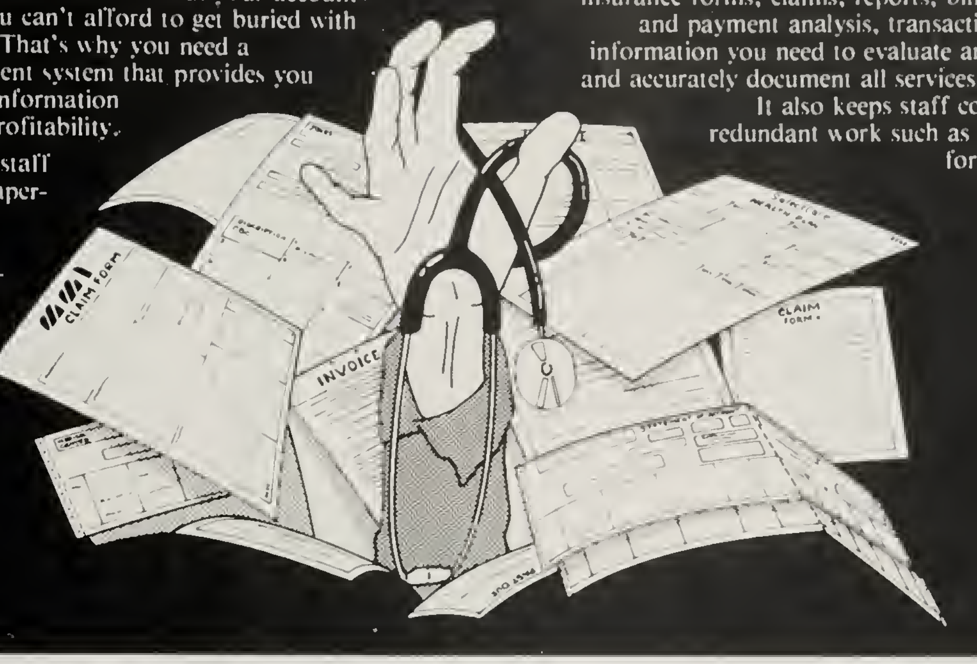

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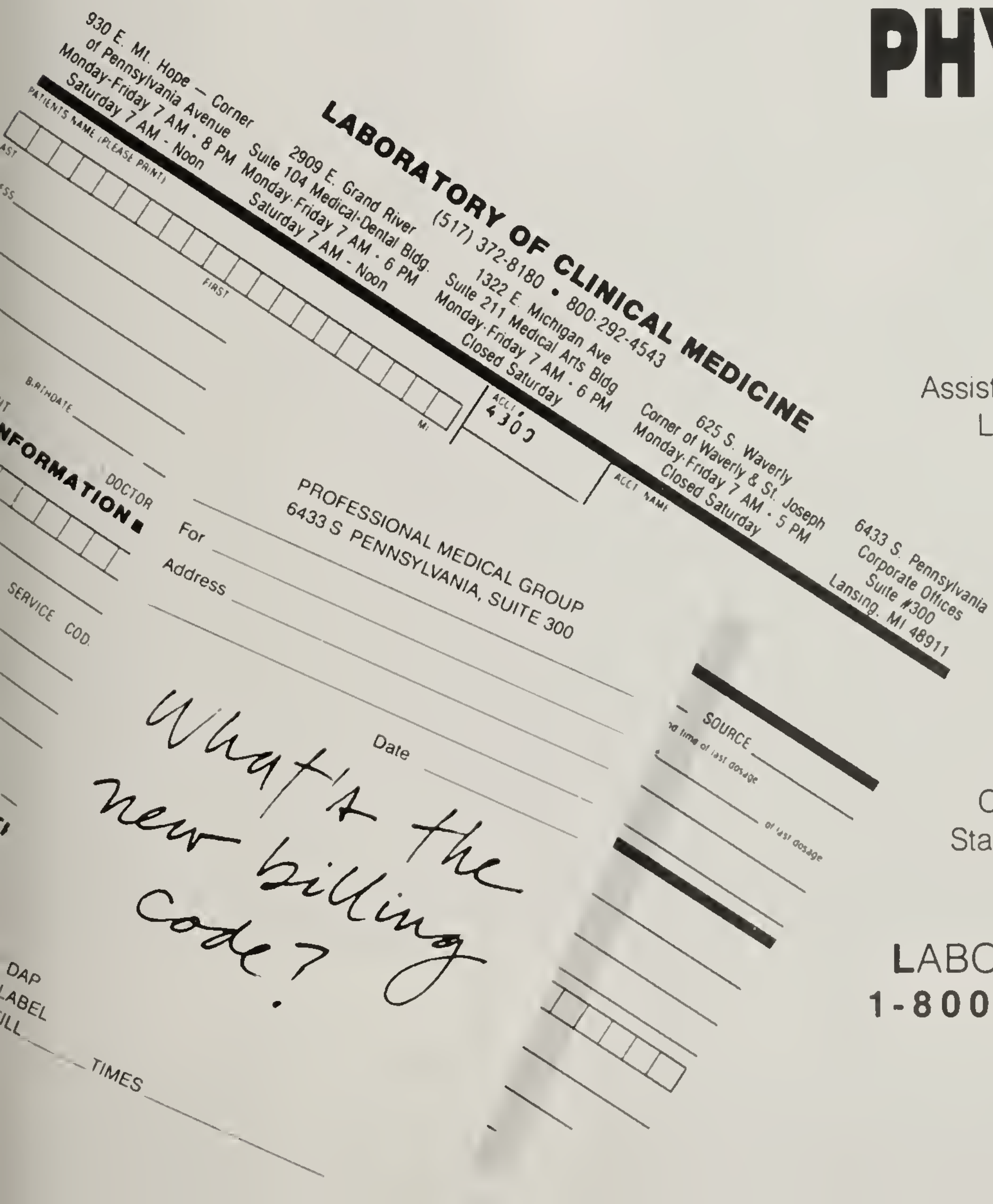

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

October

12-13, Office Procedures for Primary Care Physicians. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

12-14, 20th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids, Michigan. **Sponsors:** MSU College of Human Medicine, International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Bldg., 1900 Wealthy S.E., Suite #290, Grand Rapids, MI 49506. (616) 774-0440. **Approved for:** 18 hours Category I Credit.

18, Pediatric Urology for the Practitioner. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 10 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial and Behavioral Issues. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. **Approved for:** 13 hours Category I Credit.

20-21, Psychiatry Update 1989 - A Tribute to Raymond W. Waggoner, MD. Location: The Michigan Inn, Southfield, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 12 hours Category I Credit.

21, Great Lakes/Midwest Chronic Fatigue Syndrome Conference. Location: Pfister Hotel, Milwaukee, Wisconsin. **Sponsors:** The Medical College of Wisconsin, The University of Wisconsin School of Medicine-Sinai Samaritan Milwaukee Clinical Campus, Cardinal Stritch College, Department of Nursing, Abbott Laboratories, Schwarz Pharma, T. J. Hale Co., and Upjohn Co. **Contact:** Great Lakes/Midwest CFS Conference, 1001 W. Jonathan Lane, Milwaukee, WI 53217. **Approved for:** 6.5 hours Category I Credit.

21, 2nd Annual Cardiovascular Management Update. Location: Ritz-Carlton Hotel, Dearborn. **Sponsor:** American Heart Association of Michigan. **Contact:** Lori Hall, Program Consultant, American Heart Association of Michigan, 16310 W. 12 Mile Road, Lathrup Village, MI 48076. (313) 557-9500. **Approved for:** 6 hours Category I Credit.

25-28, Midwest Addictions Conference. Location: Detroit Radisson Hotel, Detroit Airport. **Sponsors:** Samaritan Health Center, American Medical Society on Alcoholism and Other Drug Dependencies, Western Michigan Addictionology Consultants, Inc., Michigan Psychological Association. **Contact:** Diane Campbell, Samaritan Health Center, 5555 Conner Ave., Detroit, MI 48213. (313) 579-4925. **Approved for:** 26 hours Category I Credit.

26-27, Critical Care Issues in the Care of the Elderly. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Geriatric Medicine, Department of Internal Medicine VAMC. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

November

2-4, Modern Perinatal Problems: An Update for the Practicing Obstetrician/Gynecologist. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

7, Current Topics In Pediatric Infectious Diseases. Location: Children's Hospital of Michigan Auditorium, Detroit, Michigan. **Sponsor:** Children's Hospital of Michigan. **Contact:** Education Services Department, Children's Hospital of Michigan. (313) 745-5455. **Approved for:** 4 hours Category I Credit.

9-10, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313)763-1400. **Approved for:** 19 hours Category I Credit.

10-11, 37th Annual Detroit Trauma Symposium, Harper Hospital, Detroit. Contact: Marjorie Norum, Dept. of Surgery, Harper Hospital, 3990 John R, Detroit, MI 48201. (313) 745-2345.

11, Fifteenth Annual Symposium, How Psychoanalytic Therapy Works: A Contemporary Perspectice. Location: Hyatt Regency, Fairlane Town Center, Dearborn, Michigan. **Contact:** The Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633. **Approved for:** 6 hours Category I Credit.

13-14, 8th Annual Michigan Statewide Conference on Child Abuse and Neglect: Child Abuse and Substance Abuse. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, University of Michigan Child Protection Team. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

17, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

18-19, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Karen

Brown, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

18, EveryDoc's Pediatric Dermatology. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Department of Dermatology. **Contact:** Diane Davis, Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202. (313) 876-3073 or 800-888-4340. **Approved for:** 4.5 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial & Behavioral Issues. Location: Towsley Center, Ann Arbor Michigan. **Sponsors:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, Michigan Affiliate — American Diabetes Association. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

29-30, Second Annual Symposium on the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

December

4-6, Emergency Medicine: Orthopedics. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 17 hours Category I Credit.

8, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

9, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

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WEDNESDAY, NOVEMBER 22, 1989

OBJECTIVES

1. To provide an update on new developments in diagnosis of breast cancer.
2. To increase skills in the use and interpretation of diagnostic tools in the prognosis of breast cancer.
3. To update current knowledge on the use of adjuvant chemotherapy.
4. To critique current uses of chemotherapy in breast cancer.

CONFERENCE DESCRIPTION

This in depth program is designed for practicing oncologists, pathologists, surgeons, residents and fellows as well as basic researchers to review current knowledge in diagnosis and management of breast cancer. The meeting will be limited to 300 participants who will be accomodated on a first come first served basis. The conference will be held at the Engineering Society of Detroit, 100 Farnsworth, Detroit, MI 48202. This conference is partially supported by the Suzanne Korman Morton Cancer Research Fund and Warner-Lambert/Parke-Davis.

SCHEDULED SPEAKERS

"The Need of Predictors for Breast Cancer", **Michael J. Brennan, M.D.**, Michigan Cancer Foundation, Detroit, MI; "The New and the Old in Breast Cancer Diagnosis", **Leopold Koss, M.D.**, Montefiore Medical Center, New York, NY; "Morphological Basis of Breast Cancer Prognosis" **Jose Russo, M.D., Conference Director,** Michigan Cancer Foundation, Detroit, MI; "The MCF Experience in Breast Cancer Prognosis", **Helen Ownby, Ph.D.**, Michigan Cancer Foundation, Detroit, MI; "The Comorbidity Factor in the Decision Process of Adjuvant Chemotherapy", **William Satariano, Ph.D.**, University of California, Berkeley, CA; A Critical Assessment of Adjuvant Therapy for Breast Cancer", **John H. Glick, M.D.**, University of Pennsylvania, Philadelphia, PA; "The Use of Prognostic Factors in the Selection of Therapy for Patients with Early Breast Cancer", **I.Craig Henderson, M.D.**, Dana-Farber Cancer Institute, Boston, MA; **PANEL DISCUSSION: Panel Members: L. Baker, D.O. (Chairperson), M.J. Brennan, M.D.; J.H. Glick, M.D.; I.C. Henderson, M.D.; L. Koss, M.D.; S. Martino, D.O.; H. Ownby, Ph.D.; J. Russo, M.D.; W. Satariano, Ph.D.; G. Wilson, M.D.**

TUITION

The registration fee is $75 for professionals and $25 for residents and fellows. The fee includes coffee breaks and lunch. Due to the expected number of participants for this conference, early registration is highly advised. Residents and Fellows must provide a letter from their program director or supervisor certifying their status. In the event of cancellation, the fee will be refunded in full if notification is received two weeks prior to the initiation of this conference. All registration fees should be in US currency and submitted with registration forms. All checks should be made payable to the Michigan Cancer Foundation.

CONTINUING MEDICAL EDUCATION CREDIT

The Michigan State Medical Society Committee on CME Programming, an organization accredited by the MSM Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 6.5 credit hours in Category I towards the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed.

REGISTRATION INFORMATION

For additional information call or write to Ms. Kathy Dauphinais (313) 833-0710, ext: 362 or Ms. Vivian Powell (313) 833-0710, ext: 219, Michigan Cancer Foundation, 110 East Warren Avenue, Detroit, MI 48201.

MEETINGS

MSMS Meetings

October

11,12, MSMS/PSG Third Party Reimbursement and Coding. 11th — Amway Grand Plaza, Grand Rapids, Michigan. 12th — Somerset Inn, Troy, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

18,19, MSMS/PSG Retirement Planning. 18th — Hyatt Regency, Dearborn, Michigan. 19th — Amway Grand Plaza, Grand Rapids, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

25, MSMS/PSG Starting Yourself in Medical Practice, Dearborn Inn, Dearborn, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

November

1, 1989 Board of Directors Meeting, MSMS Headquarters, East Lansing. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351 Ext. 33.

7-9, Annual Scientific Meeting, Hyatt Regency, Dearborn. Contact: Sherry Fent, chief of physician education, (517) 337-1351 Ext. 28.

AMA Meetings

October

19-21, Confronting the Issues Together, Sheraton Washington Hotel, Washington, DC. Contact: Belle Kulick, (312) 645-5450.

26-27, Drug Regulation and Availability Conference, Sheraton Premiere Hotel, Tysons Corner/Vienna, VA. Contact: Patti Fitzgerald (312) 645-5581.

27-28, Clinical Update in Geriatric Medicine Conference, Drake Hotel, Chicago, IL. Contact: Craig G. May, (312) 645-5360.

Michigan Specialty Society Meetings

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633.

National Specialty Society Meetings

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016. (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068. (312) 825-5586.

14-19, American Psychiatric Association, Interim Meeting, Adam's Mark, Philadelphia, PA. Contact: American Psychiatric Association, 1400 K Street NW, Washington, DC 20005. (202) 682-6000.

18-22, American Society of Internal Medicine 33rd Annual Meeting — Costs, Quality & Controls: Seeking the Right Balance. Contact: Dana Jennings (202) 289-1700.

21, American Heart Association of Michigan — "Winning Tactics for Managing Ischemic Heart Disease" Dearborn, MI. Contact: Lori Hall, Program Consultant, American Heart Association of Michigan,16310 W. 12 Mile Road, Lathrup Village, MI 48076. (313) 557-9500 Extension 343.

21-23, American College of Nuclear Medicine Scientific Meeting, Swiss Grand, Chicago, IL. Contact: American College of Nuclear Medicine, Box 5887, Columbus, GA 31906. (404) 322-8049.

21-24, American College of Nuclear Physicians Interim Meeting, Loews L'Enfant Plaza Hotel, Washington, DC. Contact: American College of Nuclear Physicians, 1101 Connecticut Ave., NW, Suite 700, Washington, DC 20036. (202) 857-1135.

21-26, American Academy of Pediatrics Annual Meeting, Chicago, IL, Contact: American Academy of Pediatrics, 141 Northwest Point Road, P. O. Box 927, Elk Grove Village, IL 60007. (312) 288-5005.

23-25, American College of Gastroenterology Annual Meeting, Marriott Hotel, New Orleans, LA. Contact: American College of Gastroenterology, 13 Elm St., Manchester, MA 01944. (617) 927-8330.

28-11/3, American Society of Clinical Pathologists Annual Scientific Meeting, Ramada Renaissance, Washington, DC. Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612. (312) 738-1336.

28-11/3, College of American Pathologists Annual Scientific Meeting, Washington Ramada, Washington, DC, Contact: College of American Pathologists, 5202 Old Orchard Road, Skokie, IL 60077. (312) 966-5700.

29-11/2, American Academy of Ophthalmology Annual Meeting, Convention Center, New Orleans, LA, Contact: American Academy of Ophthalmology, P. O. Box 7424, 655 Beach, San Francisco, CA 94120. (415) 561-8500.

29-11/3, American Society of Plastic and Reconstructive Surgeons Annual Scientific Meeting, San Francisco Hilton, San Francisco, CA, Contact: American Society of Plastic and Reconstructive Surgeons, Vanderbilt Hospital, Nashville, TN 37232. (615) 322-3451.

29-11/4, Congress of Neurological Surgeons Annual Meeting, Atlanta, GA, Contact: Congress of Neurological Surgeons, University of Southern California, 1200 N. State Street, Los Angeles, CA 90033. (213) 226-7421.

30-11/3, American College of Chest Physicians, Annual Meeting, Sheraton/Weston, Boston MA, Contact: American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. (312) 698-2200.

30-11/3, American Academy of Occupational Medicine Interim Meeting, Sheraton Inner Harbor, Baltimore, MD, Contact: American Academy of Occupational Medicine, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005. (312) 228-6850.

November

3-4, American Academy of Pain Medicine, 1989 Annual Conference, Dallas, TX, Contact: American Academy of Pain Medicine, 43 East Ohio #914, Chicago, IL 60611. (312) 645-0083.

3-5, Broad Scope of Pain Management, Annual Conference, Dallas, TX, Contact: American Academy of Pain Medicine, 43 East Ohio Street, Suite 914, Chicago, IL, 60611. (312) 645-0083.

5-10, American Academy of Physical Medicine and Rehabilitation, Convention Center, San Antonio, TX, Contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603-6107. (312) 922-9366.

Other Meetings

October

20, Multiple Sclerosis-1989 Conference. Contact: David Irwin, Hospitals Communications, (614) 459-3909.

November

8, Michigan Board of Vocational Experts, Fourth Bi-Annual Conference, Contact: John Caknipe or Ann Tremblay at (313) 326-4280.

CLASSIFIEDS

The rate for classified advertising in Michigan Medicine is 80 cents per word, with a minimum charge of $40.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

ASPEN MEDICAL GROUP, AN INDEPENDENT, MULTISPECIALTY GROUP in Minneapolis/St. Paul, MN, seeks associates in: Family Practice, Pediatrics, Internal Medicine, Orthopedic Surgery, Obstetrics/Gynecology and Urgent Care. Competitive earnings, excellent benefits, reasonable call and clinic responsibilities. Reply: Maureen Reed, MD, ASPEN MEDICAL GROUP, 1020 Bandana Blvd. West, Suite 100, Saint Paul, MN 55108. Call: (612) 641-7178.

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PRESIDENT'S PAGE

Professional Liability — The Swedish Experience

By Robert E. Paxton, MD

Continental atmosphere. The Archipelago. Historic Stockholm. Towering pines and birch-studded forests. Massive rock with lakes, streams, inlets, rivers and seas everywhere. Picturesque fishing villages and resort towns. Neat and tidy farms with groomed cattle, riding horses and large fields of golden grain. Industrial cities with endless lines of traffic. All of the above describe my lasting impressions of Sweden — a country to which I recently travelled along with 26 other medical, legal and legislative leaders from Michigan.

Much more permanent and durable than my impressions described above is the warmth and depth of feeling I saw expressed by those reserved but genuine, gentle people we call "Swedes." We have much to learn from these people and their culture.

By now you have heard or read several reports about the multi-disciplined exposition to Sweden that took place this past August — a group with divergent ideas and purposes which sought to evaluate how Sweden manages its medical liability problem. It was a very productive trip that should have some far-reaching benefits for the health care of Michigan as well as for MSMS. For the remainder of this President's Page, I would like to zero in on a couple of ideas I formulated from the trip — ideas which I feel should be promoted by MSMS.

First of all, you must realize that it would be next to impossible to get a group of legislators, a representative from the governor's office, lawyers, doctors, insurance companies, and hospital administrators, along with a sociologist and public consultant, together for an hour-long meeting in Lansing to discuss the professional liability problem. And yet for 12 days these very people literally lived together, ate together, were exposed to the Swedish health care system together, socialized together with our Swedish hosts, and together, candidly discussed our observations and biases.

"Togetherness" important

This "togetherness" taught me an important lesson that I hope can direct the "tone," if not the nature, of our future attempts to resolve the liability issue. This exposure to each other created a mutual feeling of respect and a sincere desire to understand each others' perspectives. We worked together in this process and it seemed as if progress actually was in the making. Perhaps only with such cooperative ventures can a consensus be developed that will lead to a long-term solution for us.

Do not misunderstand me! I am not naive. I have not become "soft." I have not lost sight of our goals. Furthermore, I do not underestimate the struggle that lies ahead as we try to make some real sense out of our scrambled professional liability mess in Michigan. What I do realize is that to obtain a solution we must respectfully work with all those involved in the process. Only in this way will we be successful and see some real results from our efforts.

Another significant observation is that MSMS must aggressively pursue the evaluation of our physician licensing and disciplining process. We must support any valid change that is needed. Permeating the Swedish licensing and disciplinary process is the emphasis on preventive and educational measures without necessarily being punitive for the physician. In fact, it is geared to encourage dialogue by the doctor involved in any maloccurrence or medical injury to the patient. However, to insure the credibility of the system to the public, I encourage increased consumer representation on our disciplinary boards.

I am now convinced that we, too, should be supportive of increased public representation on the board that will make judgements after sufficient and appropriate expert medical testimony is heard. The seed for this thought was established for me earlier this year with a survey of midwest medical board members conducted by the sociology and psychiatric departments at Wayne State University. Their findings concluded that there is indeed public distrust of a physician-dominated board. Exposure to the Swedish Medical Responsibility Board confirmed my belief that we should move in this direction. Perhaps this is a radical departure from a long time conviction that physician dominance is necessary. However, I'm sure that if we want to gain public support for any changes we seek in our tort adjudication system, we need to seriously consider such a move.

More "heart" needed

Let me conclude with an important observation that I feel must be promoted. The Swedish culture and attitude is the basis for whatever success their liability system achieves. To follow their example, our people must be more responsible for their own actions, more trustworthy and less aggressive; must demonstrate a deeper concern for their fellow man, and not be so confrontational. Americans must increase their sense of social responsibility and develop more "heart" in our free enterprise system.

The Swedes have discovered that their success is founded on a mutual trust between doctor and patient — a necessary foundation we must build upon to eliminate the malpractice crisis in Michigan. I feel that MSMS has to articulate this concept throughout the state and that success can be achieved. Americans do have a virtue in that they can readily adapt to change when necessary. In the liability arena, change we must and change we will!

Doctor Paxton is MSMS president.

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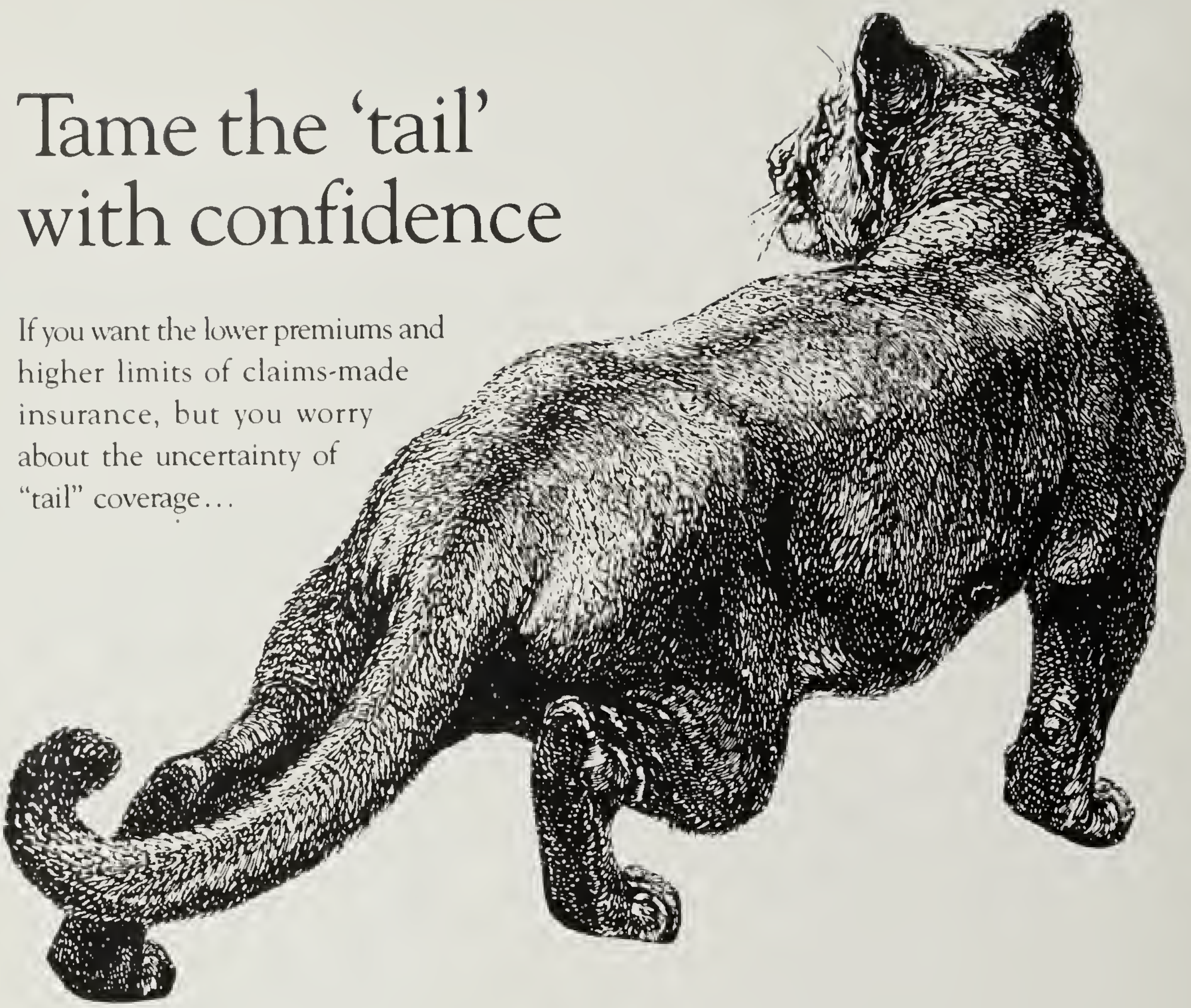

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MICHIGAN MEDICINE

Award-Winning Journal of the Michigan State Medical Society

NOVEMBER 1989
VOL. 88, NO. 11

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Cover Story

The need for organized medicine is far greater today than it ever has been. That is the message of Dorothy Kahkonen, MD, chairman of the MSMS Committee on Membership Recruitment and Retention. That also is the message of this month's cover story, which begins with a letter from Doctor Kahkonen. Following her letter, this month's cover story features profiles of the Society's five membership sections; an examination of the value of AMA membership, presented by Frank B. Walker, MD, and Robert D. Burton, MD, plus an examination of the AMA by Wayne State University medical student Karen VanderWall; a feature on the MSMS Auxiliary; an explanation and chart showing where your membership dues go; a variety of demographic information and illustrations; a complete list of all MSMS committees; a list of component medical societies and contacts; and finally, a list of whom to call at MSMS.

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BCBSM seeks physician input regarding new policies

BCBSM has requested physician input as it phases in the recommendations made by Lewin/IFC, the Washington consultants hired to help BCBSM improve its operations.

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Diagnostic coding, it's here to stay!

According to BCBSM, all claims forms now will be returned unpaid if ICD-9 coding is not correctly completed.

— By Jan Woerth

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Sweden's medical malpractice system.

Cover illustration by: *Robert L. Brent.*

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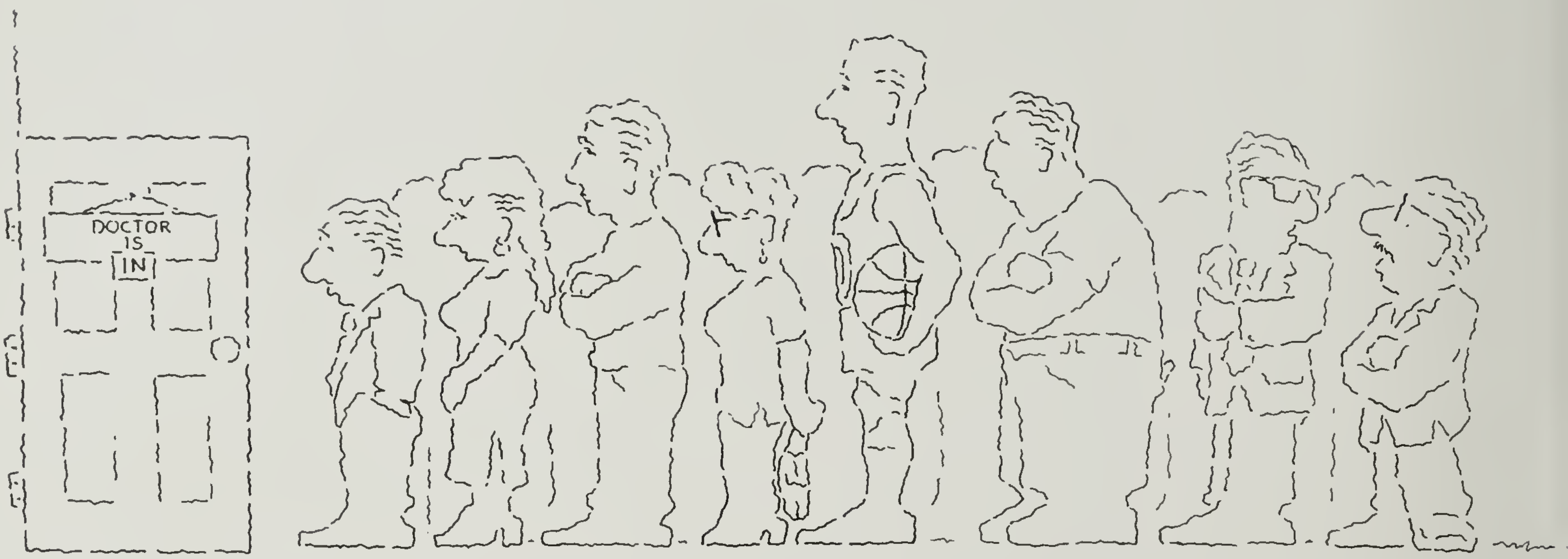

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IN MY OPINION

MSMS membership is a privilege *and* a right

By Thomas R. Berglund, MD

At a Michigan State Medical Society leadership conference years ago, Attorney General Frank Kelley stated that "Your drivers license is a right not a privilege." I would like to turn his statement around a bit and apply it to my philosophy about being a member of MSMS. To me, it is a privilege and a right.

MSMS is the one organization for all physicians, regardless of specialty. It is our umbrella organization. Membership dues amount to about one dollar per day. This is a small price to pay for what MSMS does for each of us.

I must say that I strongly believe all MSMS members, in addition to belonging to MSMS, should belong to the American Medical Association. Having been a delegate to the AMA for 12 years I can tell you that it is the one organization that speaks for all of us in Washington, DC. The AMA also interrelates with all specialty groups and other medical-related groups.

A strong, political force

MSMS' legislative activity is one area in which I have played a proud and active role over the past 25 years. I have witnessed many accomplishments in this arena. Several bills MSMS has supported actively over the years include the safety plate glass bill, the bill to get the lead out of paint, and the mandatory seatbelt law. MSMS was the physicians' advocate in the malpractice reform package of 1986 and continued to work in that area. A real positive for all physicians was MSMS' success getting pension protection legislation passed last year. MSMS currently is taking the lead in promoting legislation to restrict the use of all-terrain vehicles. MSMS has worked hard — and continues to work hard — as an advocate not only for physicians, but also for patients.

MSMS and AMA lobbying efforts are among the most effective and well known in both Lansing and Washington, DC. Both organizations' political action committees – MDPAC and AMPAC – have been effective in getting legislators elected who are sympathetic to medicine's causes.

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I urge each of you who is not a member of MSMS and the AMA to join this year. Together we can have a great impact, but "divided we fall." I have felt privileged to be able to practice medicine for the past 28 years and to be an involved member of MSMS. Come join us.

Doctor Berglund is MSMS secretary and is a member of the MSMS Committee on Publications.

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The room renovation is fairly well restricted to the need for a sink, and a plumber to install it.

If anyone has ideas for the furnishings or for underwriting the renovation costs, please let me know. Thank you for your help.

Nancy Siegrist, director
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The W.K. Kellogg Foundation is pleased to announce the availability of Kellogg National Fellowship awards for 1990. Initiated in 1980, the program is designed to prepare leaders who can function effectively and knowledgeably in dealing with complex problems where narrow expertise is not sufficient. It seeks to involve professional men and women in the earlier years of their careers who are interested in developing interdisciplinary and cross-cultural perspectives on contemporary human and social problems.

The Fellowship awards will be made on behalf of up to 50 individuals of exceptional merit and competence who have exhibited leadership potential in their community, organization, or profession. To be eligible for the three-year program, an applicant must be a US citizen, accept responsibility to participate in *all* activities related to the program, and receive 25 percent released time from his/her employer to carry out a non-degree, self-directed learning plan to expand personal horizons beyond the confines of a chosen profession. Individuals employed in both the non-profit and for-profit sectors may apply.

The award includes $35,000 for the development and completion of the learning plan and $5,000 to be used only for travel expenses incurred while participating in required seminars.

The deadline for applications is December 15. For an application, or for more information, write: Applications, Kellogg National Fellowship Program, W.K. Kellogg Foundation, 400 North Avenue, Battle Creek, MI 49017-3398. For information call: 616/969-2001. For an application call: 616/969-2005.

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MEDICAL NEWSFRONTS

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Beaumont Clinics part of national cholesterol study

Fifty percent of adult Americans have high cholesterol, a condition linked with coronary heart disease, the number one killer in the nation.

Individuals ages 18 to 70 years old with high cholesterol levels may benefit from research being conducted at the William Beaumont Hospital Clinics of Preventive and Nutritional Medicine.

Part of a nationwide research trial, the study is examining the effects of diet and treatment with Lopid-MR, a new form of a proved cholesterol-modifying drug.

The drug under investigation, also known as gemfibrozil, lowers total and low-density lipoprotein (LDL) cholesterol and raises high-density lipoprotein (HDL) cholesterol. HDL is known as the "good" cholesterol because it helps to remove excess cholesterol from tissues, so high levels are beneficial. LDL is often referred to as the "bad" cholesterol because it carries cholesterol to the cells.

Study volunteers first will be placed on a cholesterol-lowering diet. If their cholesterol levels remain high, drug treatment will be added. Volunteers will be treated for a period of 24 weeks.

For more information, contact Beaumont Preventive and Nutritional Medicine at (313) 646-6500.

Kellogg grant funds WSU project for inner-city adolescents

The Wayne State University School of Medicine is launching a program that will help inner-city adolescents and young adults learn simultaneously about personal health and computers. The program is being funded by a one-year grant from the W.K. Kellogg Foundation.

The program involves developing computer software, or programming, that will assess an adolescent or young adult for high-risk health problems. At the same time, the program will provide health information to the individual that will help reduce high risks.

"In the United States, a startling percentage of all illness and injury to adolescents and young adults is due to external or social factors, such as drug abuse, educational failure, motor vehicle accidents, homicide and suicide," notes Howard Schubiner, MD, WSU assistant professor of pediatrics and internal medicine and director of the program. "All of these factors are potentially preventable. The Kellogg grant will enable us to develop a system to assess individuals in this target group for risks and to provide methods for intervention."

The computer program will be developed based on the "Safe-Times" health-assessment questionnaire that was developed for use in a black, inner city population. Doctor Schubiner will involve teens and young adults from this target group in the process of selecting the most effective educational materials for use in developing the software.

In addition, the computer program will provide information to educators, counselors, health-providers and parents about risk levels among groups of adolescents.

Tracking trends in risk profiles will help to target specific health education efforts at groups that are more at risk in certain areas, Doctor Schubiner explains. For example, the number of adolescents who are depressed may increase over time while those at risk for drug or alcohol abuse may fall.

Blood recycling technique is becoming more popular

In an era of intermittent blood shortages and widespread concern about infectious diseases, more people are choosing to be their own blood donors.

And for many, a technique called intraoperative autologous transfusion (IAT) is making self-donation even easier. IAT involves the recovery and reinfusion of blood lost during surgery.

Developed over the last 20 years for use in open heart surgery — a procedure in which massive amounts of blood may be lost — IAT is now used in many emergency and elective surgeries including hip replacement, prostate surgery, and major vascular procedures.

"IAT doesn't completely eliminate the need for donated blood from blood banks, but it reduces the need in 20 to 50 percent of surgical cases," according to Steven Malcom, manager of IAT, Greenfield Health Systems Corporation, which services 15 Detroit-area hospitals.

During IAT, blood that is lost from the surgical site is suctioned to a nearby machine or storage container. Depending upon the type of IAT used, the blood may or may not be separated into components. In a matter of minutes, the recovered blood is ready to be given back to the patient. The procedure does not prolong or complicate surgery in any way.

A related procedure called pre-donation also has been increasing in popularity in recent years. Pre-donation involves donating blood ahead of time in preparation for elective surgery. Pre-donation requires a great deal of planning. Donations might need to be scheduled over a two- or three-week period, one unit of blood at a time.

When there isn't time to plan ahead, IAT is the only self-donation option. Even in cases where a patient has chosen predonation, IAT is a valuable alternative in case blood loss is greater than expected.

Normally, blood lost during surgery is simply discarded. By choosing IAT, however, patients can help hospitals and blood banks conserve their precious blood reserves for other emergencies.

Continued on page 10

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Henry Ford receives $50,000 planning grant

Henry Ford Hospital has been awarded a $50,000 planning grant from one of the nation's largest philanthropies to reorganize its nursing services to improve patient care.

Henry Ford Hospital is one of 40 hospitals and hospital networks selected nationwide from more than 650 to receive one-year grants from the Philadelphia, Pennsylvania-based Pew Charitable Trusts under a $26.8 million program, "Strengthening Hospital Nursing: A Program to Improve Patient Care."

Intended to address the shortage of hospital nurses, the program is co-funded by the Robert Wood Johnson Foundation, which awarded an additional 40 grants under the program.

The funds were available to non-profit general hospitals with 300 or more beds and consortia of smaller hospitals. More than 45 percent of all US non-profit hospitals with more than 300 beds applied for funds under the program.

During the planning year, Henry Ford Hospital will develop a detailed five-year strategy for restructuring its nursing services.

Up to 20 hospitals or networks with the most promising plans will be selected by foundation officials to receive five-year grants of up to $1 million each to carry out their strategies.

Henry Ford Hospital, under the direction of Vice President of Nursing Dorothy Deremo, will use the one-year planning phase to address:

- the organization of patient care systems;
- communication between nursing and medical staff;
- the coordination of housekeeping, dietary and pharmacy services with those of nursing;
- reward systems for nurses; and
- nursing's role in hospital governance and executive management.

In addition to the grant funds, the project will receive technical assistance from Barbara A. Donaho, RN, vice president for nursing and patient services at Shands Hospital at the University of Florida in Gainesville, who directs the program for the two philanthropies.

Resource available for placing difficult patients

One call to The Brown Schools National Information & Referral Service enables mental health professionals to find treatment facilities for difficult-to-treat patients. The nation's first full-service data clearinghouse designed to serve professionals, The Brown Schools National Information & Referral Service provides professionals with access to information on over 2,000 psychiatric and rehabilitation facilities from coast to coast.

Referral specialists use the data management system to cross reference up to seven criteria to identify the treatment facilities best suited to the patient's needs. The information, including hospital location and size, the variety of programs offered and available funding data, is provided at no charge.

The toll-free number is available for use as often as information and referral services are needed. Service hours are 8:00 a.m. to 5:30 p.m. (CST), Monday through Friday. After-hours support is managed by staff on call through a professional answering service.

The facilities in the data base must meet selection criteria to participate. Criteria can include accreditation by the Joint Commission on Accreditation of Healthcare Organizations, membership in the National Association of

Continued on page 11

Physicians in the News

Frank B. Walker, MD, a Detroit pathologist and chairman of the MSMS Board of Directors, is winner of the 1989 American Society of Clinical Pathologists/College of American Pathologists (ASCP/CAP) Distinguished Service Award. Doctor Walker has been a member of ASCP and CAP since 1963 and has contributed much of his time and talent to both organizations. He has held a variety of positions with these organizations and also has been very active in the American Medical Association, the American Board of Pathology, the Council on Medical Specialty Societies, the Michigan State Medical Society, and the American Board of Pathologists.

Harold I. Blumenstein, MD, an Essexville radiologist, is one of the newest fellows of the American College of Radiology. Doctor Blumenstein was recognized for his exceptional contributions to scientific and clinical research in the field of radiology. Criteria for this honor also includes performance of outstanding service as a teacher of radiology, service to organized medicine, and an outstanding reputation among colleagues and the local community.

Douglas W. Macdonald, MD, senior vice president of the Oxford Institute Network of Care, Oxford, Michigan, is now certified by the American Society of Addiction Medicine. The professional society is recognized as the major national and international organization for physicians who specialize in addiction medicine. After graduating from the University of Ottawa, Canada, he completed his internship at Bishop De Goesbriand Hospital in Vermont. He then continued his education at St. Vincent Hospital and Medical Center, Ohio; Lahey Clinic, Boston; and St. Vincent Charity Hospital, Cleveland. Doctor Macdonald is active member of the MSMS Steering Committee on the Program to Assist Impaired Physicians. He also serves on the Impaired Physicians committees for Wayne County and Oakland County Medical Societies.

Ruth Backus Hoppe, MD, FACP, is new associate dean for Preclinical Curriculum, Admissions and Student Programs, Michigan State University College of Human Medicine. Doctor Hoppe is a professor of medicine and has been on staff since 1975. She is a graduate of the University of Michigan Medical School and holds a bachelor's of science degree from MSU. She also was recently appointed to membership on the National Board of Medical Examiners Part I Behavioral Sciences Test Committee.

Harry R. Zemmer, MD, and his wife Adelaide, will be returning to the missionfield of Africa in January 1990. Doctor Zemmer will be retiring from his private practice in Lapeer this year at the age of 67, but will continue to do surgical work in Africa.

The Zemmers served as missionaries to the Belgian Congo back in 1954-1960. They built and operated a 28-bed hospital which was 200 miles from the nearest town. The hospital served 185,000 people and the clinic staff saw several hundred patients a day. In the operating room, Adelaide served as the anesthetist. Her experience as a former kindergarten teacher and principal at the Second Ward School in Lapeer helped her to establish a school in the Congo where she was able to teach French and the native African language. The Zemmers and their children were forced to flee the country when the 1960 revolution began.

The Zemmers will be going overseas to serve short-term periods of six to eight weeks. They will begin their work in the French-speaking nations of the Central Africa Republic and Chad. Doctor Zemmer's work over there will involve doing surgery on everything from crocodile bites to routine operations. One of his goals not only is to perform as many of these surgeries as he can, but to teach others there to do the same. Doctor Zemmer expects to make at least three trips to Africa per year, but his home will remain in Lapeer.

Doctor Zemmer attended the Moody Bible Institute in Chicago and then received his medical degree from the University of Michigan Medical School.

Continued from page 10

Private Psychiatric Hospitals, accreditation by the Council on Accreditation of Rehabilitation Facilities and clinical and professional recommendations.

The Brown Schools National Information & Referral Service network has its roots in the near half-century tradition of The Brown Schools hospitals. Historically, mental health and rehabilitation professionals have used The Brown Schools hospitals as an informal referral resource when placing difficult patients. The new service combines that expertise with computer technology to serve mental health and medical professionals nationwide.

To try this free service, call 1-800-531-5305.

Project REHAB North targets UP families recovering from chemical dependence

Project REHAB North is embarking on an innovative service for families in Upper Michigan recovering from chemical dependence. The program, PACT (Parents and Children Together) is funded by a $478,133 grant from the W.K. Kellogg Foundation, Battle Creek.

The PACT recovery program target parents and their children who are in long-term treatment at Project REHAB's residential substance abuse center in Marquette. "Parents, particularly women who have young children, often feel they have to choose between their own recovery and care of their children," states Laurence Ziomkowski, executive director of Project REHAB North.

PACT will provide for residential treatment for the parents and frequent visitation and programming with the children. This will be done through a network of temporary foster homes for families who come from outside of the Marquette community.

The PACT program will utilize the professional expertise of both Project REHAB and the substance abuse services of Marquette General Hospital. Children's services will be addressed by Marquette General Hospital's Substance Abuse Unit by utilizing a modified version of its successful "Children are People (CAP)" program. Family therapy also will be provided by the Hospital's substance abuse staff. Project REHAB will direct the project, provide case management services and develop and conduct the family/parenting classes and associated activities. Project REHAB also will provide all the housing services for the children, teens and adults.

The program design is unique not only because of the close cooperation between the two organizations, but because of the housing arrangements for the children. The provision of local foster home care makes it possible to offer an intensive family structuring continuum of care not only to residents of the city of Marquette but to the entire Upper Michigan community.

The W.K. Kellogg Foundation funding will support the formal establishment of PACT and its operation for four years. The amount of Foundation support will decrease each year with funds from other sources making up the difference.

Project REHAB was founded in March 1968 as a "drug rehabilitation" program. It has evolved into a health care agency offering a variety of services including prevention, diagnosis, treatment and rehabilitation for alcohol and drug abusers. These services are available to children, adolescents, adults, families and organizations throughout the state of Michigan.

Project REHAB programs are licensed by the state of Michigan Department of Social Services, Michigan Department of Public Health/Office of Substance Abuse Services, accredited by the Joint Commission on the Accreditation of Health Care Organizations and the American Corrections Association. Some Project REHAB programs are certified as Blue Cross/Blue Shield providers.

New Maplegrove program targets drunk drivers

A new program developed by the Henry Ford Hospital Maplegrove Treatment Center is helping drunk drivers turn an arrest into a step towards help.

The Maplegrove Alternatives Program uses a drug or alcohol-related event, such as a drunk driving offense, to force the drunk driver to examine the role of chemicals in his or her life. More than 80 people have completed the program, offered two weekends a month since January, 1989.

The program currently is held at Cottage Hospital in Grosse Pointe, but participants have come from more than a dozen communities in the Detroit metropolitan area. The program will open at additional sites in Michigan as demand for it increases.

"As a hospital-based program requiring an overnight stay, this is the first of its kind in Michigan, although it is a well-respected model in neighboring Ohio," said program coordinator Larry Campbell, MSW.

In developing the program, the Maplegrove treatment staff worked closely with local judges Bernard Friedman of the 48th District Court (Birmingham and the Bloomfields) and Stephen Cooper of the 46th District Court (Southfield).

When program participants arrive Saturday morning at eight, most are confident that they can handle their alcohol or drugs. Getting arrested?

Continued on page 12

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Plain bad luck!

On Sunday afternoon. It's usually a different story.

They have spent 26 hours listening, thinking, talking and writing about a single subject — how chemical use has affected their lives. Chances are it has done more than get them arrested. As the weekend progresses, participants begin to let down their defenses. They share with others in the eight- to 16-member group how embarrassed, ashamed and guilty their chemical use has made them feel, how it has alienated them from family members, brought reprimands from work, put them in debt or eaten into their life savings.

And as 5 p.m. Sunday arrives, participants and their family members have just heard a couple from the Wayne County Mothers Against Drunk Drivers describe the pain of losing a daughter to a drunk driver.

Clients referred to the program receive a 90-minute assessment and, if accepted, come with a family member for a 90-minute Thursday evening orientation before the weekend. The weekend program is conducted by two chemical dependency treatment professionals. A follow-up evaluation comes after the weekend.

The cost of the program is $285 and is covered entirely by the participant.

A state-supported evaluation of 2,400 participants in a similar program at Deaconess Hospital in Cleveland found: 1) the rearrest rate for drunk drivers dropped from 23 percent for those jailed for the offense to 13 percent for program participants, 2) more participants remained accident-free than the control group, and 3) program attendance coupled with court mandated alcohol counseling reduced recidivism by nearly 25 percent.

For further information, contact Larry Campbell or Chuck Coyne at (313) 626-0073.

AMA is offering self-help programs on insurance processing, coding

To ensure continuous income in physicians' medical practices, as well as full and fair reimbursement, it's essential for office staff to have a complete knowledge of insurance processing and coding.

The American Medical Association is offering two self-study audiocassette and workbook programs to refine present staff's skills, and train new staff members.

Insurance Processing explains the role third-party payors play in healthcare reimbursement. It includes numerous examples of letters and forms designed for efficient and successful claims filing. Advice is given to help staff deal with slow-paying insurance companies. Hands-on exercises help staff learn and review processing procedures. Information on computerized insurance processing also is included.

Insurance Coding offers a full explanation of CPT procedural codes. Using the CPT-4 manual, staff members work through the examples and exercises to develop and improve their coding skills. They'll learn how the system works, and the various levels of coding and how to use them. Test questions are directed toward a variety of specialties.

Insurance Processing, OP-426, and *Insurance Coding*, OP-411, are available for $40 each (20 percent discount for AMA members), from the American Medical Association, Book and Pamphlet Fulfillment, P. O. Box 10946, Chicago, IL 60610-0946 or call 1-800-826-6895 with VISA or Mastercard to order. ■

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MSMS MEMBERSHIP

It begins with you

Dear Colleague:

Years ago, individual community service organizations each would have their own fundraising campaign which sometimes resulted in several groups soliciting contributions at the same time. This condition gave birth to the famous expression, "I gave at the office." Finally, someone realized that by combining their efforts, both the organizations and the public could benefit. They called this cooperative "United Way."

In several ways, organized medicine is trying to achieve the same objective by combining our resources to serve the many. This need is far greater in medicine today than it has ever been and more physicians are realizing this. Our organization truly is democratic and is the only association that can represent the concerns of you and your patients.

MSMS policy is formed annually at the House of Delegates. The policies acted upon by the House are then referred to the Board of Directors or one of the 50 committees and task forces of MSMS. These committees range from the Committee on Aging, whose activities include examining the health status of older patients, to the Committee on Medical Licensure and Discipline, which serves as a liaison to the Michigan Department of Licensing and Regulation and supports measures that will promote a fully effective Board of Medicine.

The MSMS committee structure is very active, with most committees meeting four to six times per year to explore and debate issues important to you and your patients. (Information on MSMS committees can be found beginning on page 24.)

MSMS also is active in the American Medical Association, as part of the federation of medicine, and has 24 elected representatives to the AMA House of Delegates.

Many other MSMS members actively serve at the county level as officers and committee members to help make the county organizations effective and viable associations. Each of these individual organizations helps to make the federation of organized medicine work for all its members.

We physicians are facing an increasing number of challenges which require action on our part if we are to preserve any control over our future and offer the best medical care for our patients. As individuals our effectiveness is limited; but when individuals have common goals and their voices repeat similar themes, they can become very effective. Individuals aligned in organizations with coordinated leadership can speak with one strong voice and extend influence into the legislature, business and governmental agencies, and the news media.

We must convince our nonmember colleagues that this united approach is the only way we can hope to deal with all the changing events in medicine, and that only by utilizing our combined talents and resources can we preserve our professional standards. As members, we know how well the system works, but we need more members and more financial resources to increase our influence. It is our responsibility to promote this idea to nonmembers and to persuade them to join us in making this a truly united body of physicians.

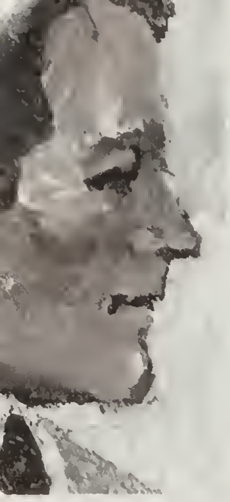
MSMS is continually recruiting new physicians to help meet the challenges to medicine during the coming months and years. I hope that each Society member will do his or her share to encourage a nonmember to join with us so that with the strength of increased numbers and financial support we can speak with a more powerful voice whenever it is needed.

Let us become united not only in numbers but also in spirit.

Sincerely,

Dorothy Kahkonen, MD

Dorothy Kahkonen, MD
Chairman,
MSMS Committee on Membership
Recruitment and Retention



Cover Story

MSMS MEMBERSHIP

sections a vital force

By Judy Marr, Editor

MSMS membership sections, though relatively new phenomena, are vital forces in determining the Society's programs and goals.

The sections provide a forum and organization for medical students, residents, hospital medical staff members, young physicians and graduates of foreign medical schools to channel their concerns into action.

All but the graduates of foreign medical schools have national-level counterparts of their sections. The MSMS Section for Graduates of Foreign Medical Schools is the first of its kind in the nation.

Each section operates as a subgroup of the MSMS House of Delegates, through which all requests for action must pass. The sections hold annual meetings in the spring, just prior to the MSMS House of Delegates meeting, when they pass resolutions for consideration by the MSMS delegates.

Each has a governing council and elects delegates and alternates to the MSMS House. Governing council chairmen are official guests at each MSMS Board meeting.

In 1989, the sections were partly responsible for introduction of the highest number of resolutions in recent memory at the MSMS annual meeting.

Following is a round-up of current section activities.

MEDICAL STUDENT SECTION

The MSMS Medical Student Section, chaired by Safa Kassab, third-year Wayne State University student, staged a major fund-raising event this fall, the first of a planned annual effort.

The students donated all proceeds from their Las Vegas night October 7 in Ann Arbor to the Michigan Chapter, American Diabetes Association.

All Michigan medical students were invited to participate, with the hope that the evening not only would raise funds for a worthy event, but also would strengthen communications between the medical schools in the state.

The Section Governing Council solicited financial support from Michigan pharmaceutical companies to rent equipment and to provide prizes for games winners.

"This is a first step to get all three schools working together and in touch with each other," said Kassab just prior to the big event. "We are expecting 150 to 200 people. We hope it works."

The students also plan a quarterly newsletter this year, book coops at each school, and resolutions for consideration by the MSMS House of Delegates.

The medical students' resolutions to the MSMS House in 1989 supported legislation to establish a health service corps for underserved areas of Michigan, and called on the AMA to encourage the US Department of Health and Human Services to eliminate the requirement that independent students submit parental information on applications for financial assistance. Both have moved on for further study and action.

"There's a hierarchy among the medical profession — medical students, residents and active physicians," observes Kassab. "Each group has its own views of the issues.

"Our section allows us to share ideas and to voice our opinions. Our ultimate goal is to have a national impact."

Section officers include Pino Colone, MSU; Charles Desibow, U-M; Jay Fischer, WSU; Brett Gerber, U-M; Rick Imirowicz, WSU; Jan Johnson, WSU; Kim Koons, U-M; Par Rihal, WSU; Laurence Truman, WSU; Karen Vanderwall, WSU; Steven Weisman, MSU, and Jerome L. Yaklic, WSU.

RESIDENT PHYSICIANS SECTION

The MSMS Resident Physicians Section (RPS) has been serving the special needs of Michigan Residents since 1982. Education programs, legislative activities and membership recruitment highlight the current goals of the Section.

Members of the 1989-90 RPS are active in MSMS through the House of Delegates, as well as at national level meetings. RPS Governing Council Chairman A. Bradley Eisenbrey, MD, PhD, Grosse Pointe Woods, won election to the AMA Council on Scientific Affairs at the AMA Interim meeting in June. In addition, Brian F. Jewell, MD, Ferndale, represents residents on the MSMS AMA Delegation.

One of the goals of Chairman Eisenbrey, MD, is membership recruitment.

MSMS soon will launch a "Resident Mentor Campaign" to encourage MSMS members to sponsor resident membership at the county, state, and national levels. MSMS mentors will commit to sponsoring resident membership dues in the AMA, MSMS, and county society. The program was initiated with the sponsorship of 40 new residents by two Wayne County Medical Society physicians, Thomas M. Sullivan, MD, and Calvin E. Schorer, MD, both of Lafayette Clinic in Detroit.

The RPS also contributes to MSMS legislative efforts and recently offered testimony before the House Appropriations Subcommittee opposing cuts to state funding for graduate medical education. The Section also will be called upon to help MSMS develop a response to legislation calling for regulation of resident work hours and supervision.

A. Bradley Eisenbrey, MD, chairman, MSMS Resident Physicians Section Governing Council, leads a discussion at a recent Section meeting.

Five members of the MSMS Resident Physicians Section take a moment to chat at a recent Section meeting. Pictured from left to right are: George E. Metropoulos, MD, senior resident, Henry Ford Hospital; Adil M. Karamali, MD, member, RPS Governing Council; James V. Palazzolo, MD, member, RPS Governing Council; Mary Moeller, MD, pediatric resident, Kalamazoo; and Section Chairman A. Bradley Eisenbrey, MD.

The RPS and the Young Physicians Section work together to promote a practice management seminar for senior residents and new physicians embarking on medical practice. The seminar covers legal and legislative issues, financial and practice marketing techniques and other useful topics to assist in running a private practice.

Governing Council members are Doctor Eisenbrey; Doctor Jewell; James V. Palazzolo, MD, Lincoln Park; Adil M. Karamali, MD, Dearborn; Alan B. Brown, MD, Ann Arbor; and Angela DeSantis, MD, Dearborn.

HOSPITAL MEDICAL STAFF SECTION

Chairman Gary Maynard, MD, points out that the HMSS, like other MSMS sections, provides a route for grass-roots physician concerns to find expression all the way to the national level.

"There is no other forum for us to discuss our hospital staff issues," he says. "It is important for us to express our concerns as a group of physicians through organized medicine."

One of the concerns currently getting Hospital Medical Staff Section attention is the issue of extending the "Good Samaritan" law to physicians providing emergency care in clinic and hospital settings.

SB 323, introduced by Sen. John J. H. Schwarz, MD, Battle Creek, which began as a 1989 MSMS HMSS resolution, was adopted by the MSMS House of Delegates, and now is under consideration by the Senate Judiciary Committee.

Section meetings also enable physicians to share information regarding the structure of their hospital staff bylaws and organization. Such information can be very valuable in smoothing physician/hospital relationships.

Gary Maynard, MD, serves as chairman of the MSMS Hospital Medical Staff Section.

A major effort of the Section is organization of MSMS Physicians Issues Presentations, called PIPs for short. These presentations by MSMS officers bring organized medicine's major concerns right into the hospital medical staff meeting.

PIPs subjects for 1989-90 include the Michigan triplicate prescription program, Michigan pension protection plan legislation, organ transplantation programs, federal legislative issues, postgraduate requirements for physician licensure, Michigan AIDS laws, certificate of need reform, and other key issues.

The MSMS Hospital Medical Staff Section, like other MSMS sections, has been a seedbed for national leadership over the years. The Section's first chairman, Peter A. Duhamel, MD, Rochester, now serves as secretary of the AMA Hospital Medical Staff Section.

Governing Council members include Doctor Maynard; Harry L. Doerr, MD, Southfield; Doctor Duhamel; Gerhard C. Endler, MD, Detroit; John A. Rupke, MD, Grand Rapids; Krishna K. Sawhney, MD, Taylor; and Devendra Sharma, MD, Tawas City.

YOUNG PHYSICIANS SECTION

The MSMS Young Physicians Section, approved on second reading at the 1988 MSMS House of Delegates meeting, has proved to be an important source of developing leadership for the Society.

Membership is open to all MSMS members under the age of 40, or those professionally employed for less than five years.

"The mission of the Young Physicians Section is to enhance the participation of

Continued on page 18

Fifty-nine delegates, alternate delegates, MSMS officers and guests gathered in Dearborn March 11 for the Fifth Assembly Meeting of the MSMS Hospital Medical Staff Section.

Richard A. Stone, MD, serves as chairman of the MSMS Young Physicians Section.

The MSMS Young Physicians Section, in cooperation with Physician Service Group Inc., an MSMS subsidiary, offers young physicians the opportunity to attend an annual workshop on financial and medical practice management. Nearly 100 young physicians gathered for the first workshop held last October.

young doctors in organized medicine and to act as an advocate for young physicians," says Chairman Richard A. Stone, MD, Mt. Clemens. "We want to assure organized medicine addresses our unique needs."

Section members take their mission seriously. Members introduced 15 resolutions at the 1989 House of Delegates meeting. Some of the issues discussed were the impact on young physicians of claims-made insurance, Blue Cross Blue Shield of Michigan audit procedures, third party cost containment programs, health services for teens, long-term care insurance, physician licensing requirements and drunk driving in Michigan.

At their 1989 section meeting, the young physicians heard addresses by acting Insurance Commissioner Dhiraj N. Shah, and by AMA Associate General Counsel Edward B. Hirshfeld, MD. Their special guest was George E. McGee, MD, chairman, AMA Young Physicians Section.

On the evaluations received from participants at the section annual meeting, 15 young physicians submitted their names to be reviewed by the MSMS Board for participation on MSMS committees.

The section, in cooperation with the MSMS subsidiary, Physician Service Group, Inc., recently presented its second annual financial and practice management seminar tailored for beginning physicians.

Governing Council members are Doctor Stone; Thomas J. Archambeau, MD, Lansing; Tama D. Abel, MD, Ann Arbor; Dean G. Sienko, MD, Lansing; Thomas M. George, MD, Kalamazoo; Mark D. Kolins, MD, Wayne, Ray F. Kiefer, MD, Muskegon.

GRADUATES OF FOREIGN MEDICAL SCHOOLS

Members of the MSMS Section for Graduates of Foreign Medical Schools probably feel as strong a sense of mission as any of the special MSMS membership groups.

Being the first such section in the country, they are aware that they are setting precedent, that other states are watching their progress, and that what they do can have national impact.

Potential for membership in the Section is high, with a total of 4,500 graduates of foreign medical schools in the state. Of this number, 2,500 are MSMS members.

One hundred delegates elected from Michigan hospitals attended the Section's first annual meeting in March 1989. Shortly after, the Section was approved on second reading by the MSMS House of Delegates.

Section delegates deliberated 20 resolutions, many dealing with issues of residency discrimination and of licensure problems. Section leaders have strengthened ties with leaders of physician ethnic groups in the state, stressing the need for unity to achieve change.

Busharat Ahmad, MD, Marquette, is chairman of the MSMS Section for Graduates of Foreign Medical Schools.

Their testimony was instrumental in the recent state rules change which equalized residency requirements for physician licensure. Another success came with the AMA House of Delegates' adoption in June of the Section's resolution calling for greater involvement of graduates of foreign medical schools in AMA policy-making.

Section members also have noted with pleasure the recent establishment of the AMA Department of Foreign Medical Graduates, and the new AMA Advisory Committee on FMGs.

Michigan Section Chairman Busharat Ahmad, MD, Marquette, has been asked to serve as chairman of the new AMA committee.

"The purpose of the Section is to convey to MSMS and the AMA our problems, regardless of ethnic or nationality backgrounds," says Doctor Ahmad.

Doctor Ahmad continually emphasizes the need for his colleagues' participation in the Section. He and other Section leaders are gearing for a major membership drive, to bring more foreign-trained Michigan physicians into the MSMS fold.

One hundred delegates elected by their hospitals to attend the first annual meeting of the MSMS Section for Graduates of Foreign Medical Schools last March applauded as their concerns found their first dedicated forum in organized medicine.

Recent Section projects include a seminar on improving communications with patients and the public. Section members are monitoring progress of national programs to study and eliminate discrimination against foreign-trained physicians.

Officers are Doctor Ahmad; Allan C. D. Brown, MD, Ann Arbor; Jose Evangelista, MD, Livonia; Vicente Gracias, MD, Grand Rapids; Byung Y. Lee, MD, Mt. Clemens; Krishna K. Sawhney, MD, Detroit, and Samir Yahia, MD, Detroit. ■

Cover Story

American Medical Association

There are 100 billion good reasons why you should join

By Frank B. Walker, MD and Robert D. Burton, MD

Why join the American Medical Association, you ask? We can give you 100 billion good reasons: The $100 billion Department of Health and Human Services annual budget.

Physicians and the patients we serve need a strong voice in how these dollars are spent — to ensure that patient care, teaching, and research are adequately funded. The best vehicle to achieve that needed voice is the American Medical Association.

Every physician is affected by the decisions made in Washington, DC, regarding health care. Yet less than half of the physicians in this country are AMA members.

Many, if not most, of our members support the AMA through membership. We send delegates to meetings each year to establish AMA policies. We are the AMA. But we need to make our AMA as strong as it can possibly be if we are to save the health care system we have built, a system that is the envy of the world.

Unity a must

Medicine must unite with single-minded dedication to the goals which all physicians share — delivery of the highest quality of care, with the maximum access permitted by available resources.

We must stand together in our national professional association so that the AMA has the resources to carry out the urgent tasks which need to be accomplished, such as pursuing cost-effectiveness, ameliorating the professional liability crisis, improving physicians' image, and much, much more.

Just as the first responsibility of each physician is to the patient, we have a collective responsibility and vested interest in how our nation bridges the gap between the growing health needs of the people and limited national resources.

Because of the progressive "graying" of the population, the high cost of new technology, and other reasons, the clinical, socioeconomic and political challenges facing the nation will grow larger with time, making the responsibility of our profession to the American people progressively larger.

The AMA is the only organization capable of representing the entire spectrum of medicine at the national level. Its House of Delegates represents all 50 states, more than 70 specialty organizations, hospital medical staffs, young physicians, medical schools, resident physicians, medical students, and physicians in the military and public health services.

Support crucial

The AMA House truly is the Congress of American medicine, and every physician in the country should be willing to give it support — support that becomes more crucial with each passing year.

At a time when federal legislative and regulatory pressures are constantly increasing, American medicine needs a strong national voice. Your financial support, your vocal support, and your contacts with legislators will keep American medicine strong.

You do not frighten physicians into joining and supporting the AMA, any more than you frighten people into building a nationwide bomb-shelter system. You must convince physicians that the right, necessary and sensible thing to do is to join the AMA.

We practice in a complex professional, economic and social framework that responds to a variety of pressures. Alone we cannot exert much influence on that framework, but collective and cohesive strength can make a difference. ■

Doctor Walker is a member of the AMA Board of Trustees and is chairman of the MSMS Board of Directors. Doctor Burton is chairman of the Michigan Delegation to the AMA and is Speaker of the MSMS House of Delegates.

Medical students are part of the AMA team

By Karen VanderWall

"I'm just a medical student." As I embark on my clinical rotations in my third year of medical school at Wayne State University School of Medicine, I find myself uttering those words often. You see, a medical student, at times, doesn't feel like an integrated part of the medical team. (Ask any medical student and he/she will be sure to agree.) When I found out that I was going to represent all the medical students from Michigan at the recent AMA Convention, I wondered what sort of impact I could make in the AMA policy. To my pleasant surprise, I found that medical students are a "part of the team" in the AMA.

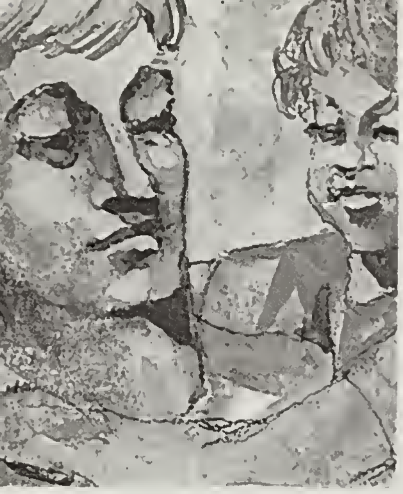
I felt warmly accepted by the Michigan Delegation. They put me right to work by assigning me the Reference Committee on Medical Education. Physicians, residents, and medical students spent an entire day delivering their opinions on such topics as residency hours, financial aid, and examinations for medical licensure. These issues are very important to medical students. We are, afterall, physicians of the future, and what better way to prepare for the practice of medicine than to be a part of the preparation and planning for the future of organized medicine.

Although the Reference Committee provided the opportunity for anyone to voice their opinion about a resolution, it was the House of Delegates that was the most exciting. Not only did we hear from prominent people such as Louis Sullivan, MD, secretary, Health and Human Services, and C. Everett Koop, MD, but we also stood as one strong voice opposing "expenditure targets."

I also attended daily meetings with the Michigan Delegation to discuss specific resolutions, and to decide how the Delegation would vote on each resolution. It was here that I felt I had the most impact on expressing what the medical student perspective was on a subject. The other members of the Michigan Delegation were very supportive of my impressions of each resolution. If I was unsure about the purpose of a resolution, another member would help clarify the purpose for me. This is how a team works — helping and supporting each other.

As the medical student member of the "Michigan team," I am proud to say I am a medical student and a member of the AMA. ■

Karen VanderWall is a member of the MSMS Medical Student Section.



Medical Societies and Auxiliaries — Working As One

By Carol M. Brown

Over the years of my involvement with the MSMS Auxiliary, I have noted the strength the organization could have if every Society member encouraged his or her spouse to join their county, state, and national medical auxiliaries.

Auxilians across the state are working with their medical society in the legislative arena, health-related programs, and in fund-raising efforts for a variety of worthy causes. Many auxilians work with community leaders in these areas serving as an extension of the physician and his or her involvement in these programs. The Boards of Education, PTAs and teachers' organizations are given information, made available by Society spouses, on drug abuse, teenage pregnancy, alcoholism, health and nutrition and AIDS.

We need more volunteers to promote these and other programs which help to improve the physician's image in the public eye. We, the Michigan State Medical Society Auxiliary, have designed a membership incentive, recruitment, and retention program to help county auxiliaries satisfy these needs in their communities with increased volunteer manpower. Please discuss membership and encourage your spouse to JOIN their county, state, and national organizations. ■

Carol Brown is membership chairman, MSMS Auxiliary. For more information on member benefits, contact: Carol M. Brown, Membership Chairman, MSMS-A, c/o Vi Heins, P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351.

Cover Story

MSMS
MEMBERSHIP
Where your dues go

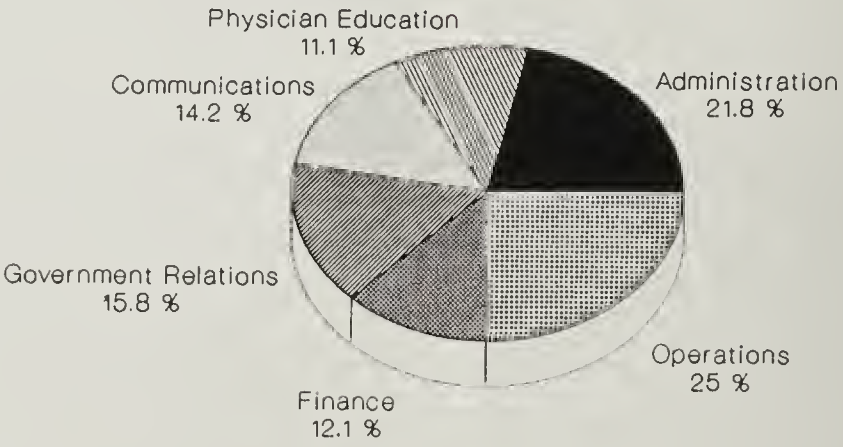
Michigan State Medical Society dues for 1990 are $350. The funds of the Society are disbursed by the Finance Committee of the MSMS Board of Directors, chaired by B. David Wilson, MD. The fiscal year for MSMS begins on December 1.

The Finance Committee acts on the recommendations of the MSMS Budget subcommittee to the Finance Committee and spends a great deal of time during the fall months analyzing every projected expense and revenue item. Final approval for the budget is secured through the MSMS Board of Directors.

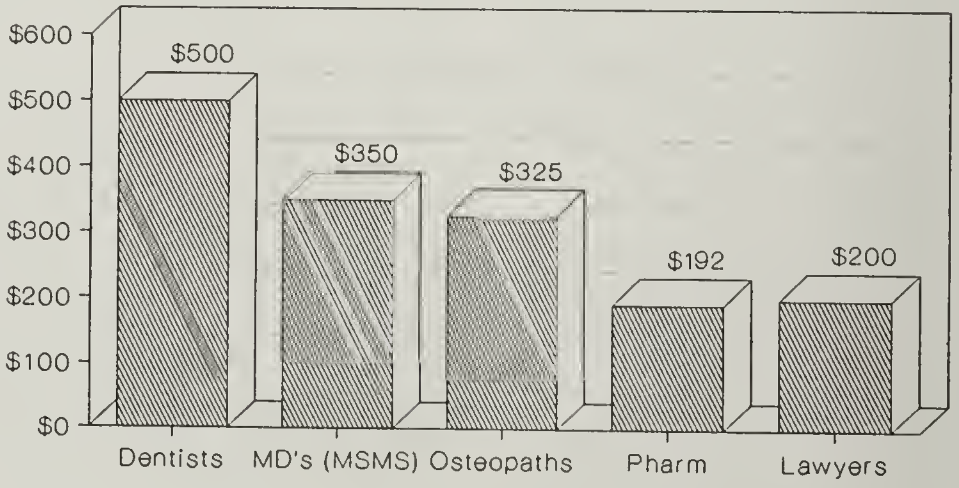
The pie chart illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is published to provide the membership with information on how MSMS revenues are spent.

The second chart shows what other Michigan professionals pay in dues and how they compare to MSMS dues.

Michigan State Medical Society



What Other Michigan Professionals Pay in Dues:



MSMS MEMBERSHIP

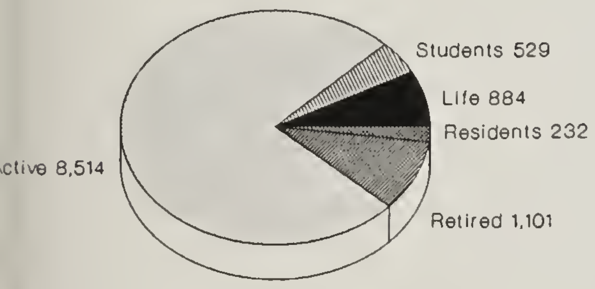
Demographic information

The following data represent a picture of current MSMS membership. The charts and graphs include information regarding the following:

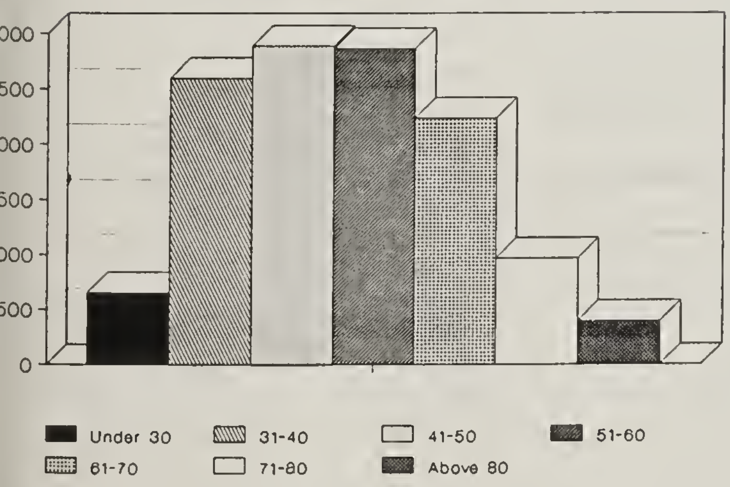
- Member distribution by class
- Member distribution by age
- The number of members who are graduates of foreign medical schools
- Member distribution by sex
- Foreign languages in which members are fluent
- Member distribution by specialty
- Miscellaneous

The Department of Membership Recruitment and Retention presents this data for your information. If you have any questions regarding this information, please contact MSMS.

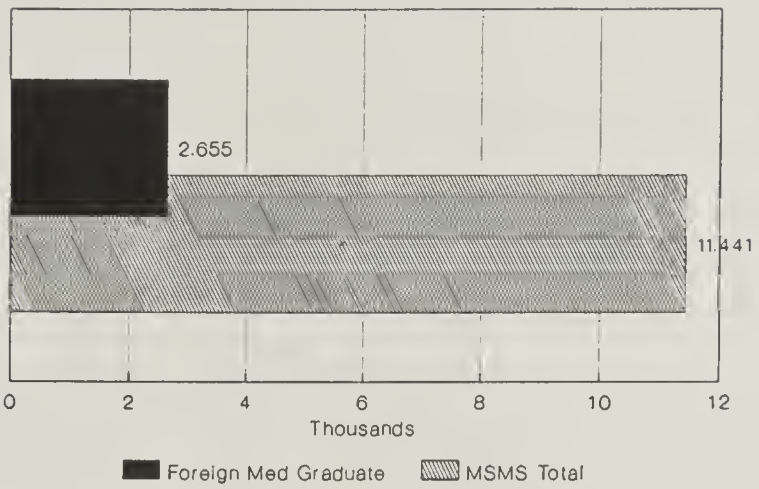
Michigan State Medical Society
Member Distribution by Class



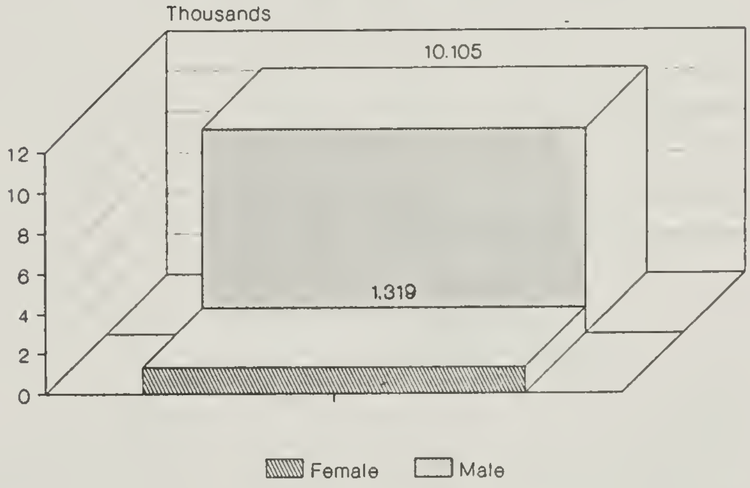
MSMS Age Distribution



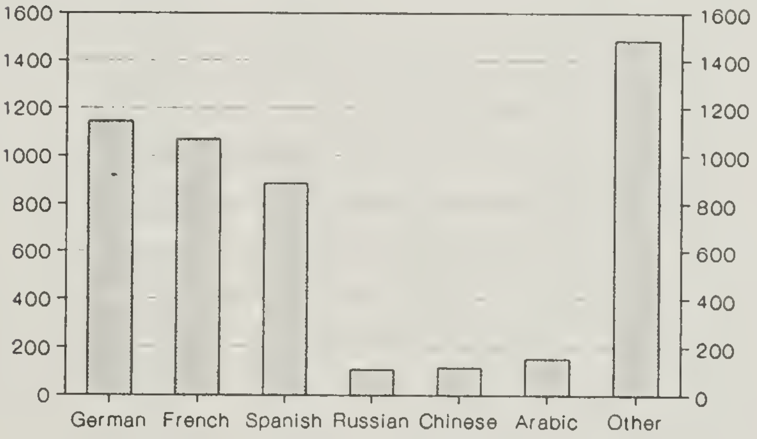
Foreign Medical Graduates



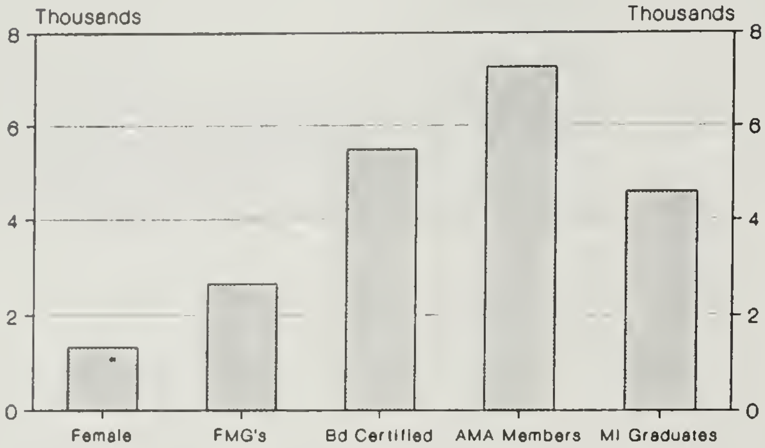
Membership Distribution by Sex



Languages Spoken



Miscellaneous Membership Information



Membership Specialty Distribution

Allergy	49
Abdominal Surgery	6
Adolescent Medicine	1
Allergy & Immunology	20
Aerospace Medicine	1
Anesthesiology	495
Cardiovascular Diseases	169
Cardiovascular Surgery	38
Child Neurology	2
Child Psychiatry	29
Clinical Pathology	26
Colon & Rectal Surgery	38
Dermatology	214
Dentists/Oral Surgery	2
Diabetes	1
Dermatopathology	1
Diagnostic Radiology	199
Emergency Medicine	186
Endocrinology	23
Family Practice	995
Gastroenterology	52
Geriatrics	6
General Practice	553
General Preventative Medicine	15
General Surgery	924
Gynecology	8
Hematology	20
Hand Surgery	12
Infectious Diseases	17
Internal Medicine	1803
Maxillofacial Surgery	3
Neurology	130
Neoplastic Diseases	2
Nephrology	16
Nuclear Medicine	13
Neonatal-Perinatal Medicine	12
Neurological Surgery	105
Nutrition	1
Obstetrics & Gynecology	895
Occupational Medicine	103
Oncology	33
Opthalmalogy	430
Orthopedic Surgery	410
Otology	1
Otorhinolaryngology	181
Psychiatry	497
Clinical Pharmacology	5
Pediatrics	643
Pediatric Allergy	12
Pediatric Cardiology	3
Pediatric Radiology	2
Pediatric Surgery	7
Public Health	44
Pediatric Hematology-Oncology	2
Physical Medicine & Rehabilitation	103
Pediatric Nephrology	1
Plastic Surgery	104
Pathology	313
Pulmonary Diseases	49
Psychoanalysis	11
Radiology	429
Rheumatology	19
Therapeutic Radiology	29
Thoracic Surgery	83
Urological Surgery	251
Vascular Surgery	4

Component medical societies are closely tied to MSMS

Every component medical society is represented on the MSMS Board of Directors by one or more elected physician(s), depending on the size of that group's membership. In addition, an MSMS staff member is assigned as a liaison and resource person for each component society. The contact persons are indicated below.

Allegan County
Directors: David J. Millard, MD
B. David Wilson, MD
Staff: Tom Plasman

Alpena-Alcona-Presque Isle Counties
Director: James L. Fenton, MD
Staff: Richard Campau

Arenac-Iosco Counties
Director: James L. Fenton, MD
Staff: Vada Davis

Barry County
Directors: R. Jack Chase, MD
Willard S. Stawski, MD
Staff: Katie Brewbaker

Bay Counties
Director: James L. Fenton, MD
Staff: Vada Davis

Berrien County
Directors: David J. Millard, MD
B. David Wilson, MD
Staff: Debbie Zannoth

Branch County
Director: Lionel E. Dorfman, MD
Staff: Rose Heald

Calhoun County
Director: Lionel E. Dorfman, MD
Staff: Rose Heald

Cass County
Directors: David J. Millard, MD
B. David Wilson, MD
Staff: Tom Plasman

Chippewa-Mackinac Counties
Director: Carl F. Hammerstrom, MD
Staff: David Fox

Clinton County
Director: Thomas C. Payne, MD
Staff: Judy Marr

Delta County
Director: Carl F. Hammerstrom, MD
Staff: David Fox

Dickinson-Iron Counties
Director: David H. Gilbert, MD
Staff: David Fox

Eaton County
Director: Thomas E. Payne, MD
Staff: Judy Marr

Genesee County
Director: Cathy O. Blight, MD
Staff: John Richards

Gogebic County
Director: David H. Gilbert, MD
Staff: David Fox

Gr. Traverse-Leelanau-Benzie Counties
Director: John W. Hall, MD
Staff: Sherry Wellman

Gratiot County
Director: Jack L. Barry, MD
Staff: Robert Ortwein

Hillsdale County
Director: Thomas E. Payne, MD
Staff: Betty McNerney

Houghton-Baraga-Keweenaw Counties
Director: David H. Gilbert, MD
Staff: David Fox

Huron County
Director: Kenneth B. Herrington, MD
Staff: Sherry Fent

Ingham County
Director: Thomas E. Payne, MD
Staff: Judy Marr

Ionia-Montcalm Counties
Directors: R. Jack Chase, MD
Willard S. Stawski, MD
Staff: Katie Brewbaker

Isabella-Clare Counties
Director: Jack L. Barry, MD
Staff: Vada Davis

Jackson County
Director: Thomas E. Payne, MD
Staff: Betty McNerney

Kalamazoo County
Directors: David J. Millard, MD
B. David Wilson, MD
Staff: Debbie Zannoth

Kent County
Directors: R. Jack Chase, MD
Willard S. Stawski, MD
Staff: Dan Farhat

Lapeer County
Director: Kenneth B. Herrington, MD
Staff: Sherry Fent

Lenawee County
Directors: Fred E. Patterson, MD
Marguerite Shearer, MD
Staff: Linda Munson

Livingston County
Directors: Fred E. Patterson, MD
Marguerite Shearer, MD
Staff: Linda Munson

Luce County
Director: Carl F. Hammerstrom, MD
Staff: David Fox

Macomb County
Directors: Peter A. Duhamel, MD
Earl G. Moehn, MD
Fred V. Minkow, MD
Staff: Sherry Wellman

Manistee County
Director: John W. Hall, MD
Staff: Richard Campau

Marquette-Alger Counties
Director: Carl F. Hammerstrom, MD
Staff: David Fox

Mason County
Director: Thomas E. Stone, MD
Staff: David Fox

Mecosta-Osceola-Lake Counties
Director: Thomas E. Stone, MD
Staff: Dan Farhat

Menominee County
Director: David H. Gilbert, MD
Staff: David Fox

Midland County
Director: Jack L. Barry, MD
Staff: Robert Ortwein

Monroe County
Directors: Marguerite Shearer, MD
Fred E. Patterson, MD
Staff: Betty McNerney

Muskegon County
Director: Thomas E. Stone, MD
Staff: David Fox

Newaygo County
Director: Thomas E. Stone, MD
Staff: Dan Farhat

North Central Counties
Director: James L. Fenton, MD
Staff: Mary Anne Ford

Northern Michigan Counties
Director: John W. Hall, MD
Staff: Mary Anne Ford

Oakland County
Directors: Peter A. Duhamel, MD
Earl G. Moehn, MD
Fred V. Minkow, MD
Staff: Kevin Kelly

Oceana County
Director: Thomas E. Stone, MD
Staff: Tom Plasman

Ontonagon County
Director: David H. Gilbert, MD
Staff: David Fox

Ottawa County
Directors: R. Jack Chase, MD
Willard S. Stawski, MD
Staff: Katie Brewbaker

Saginaw County
Director: Jack L. Barry, MD
Staff: Robert Ortwein

St. Clair County
Director: Kenneth B. Herrington, MD
Staff: Richard Campau

St. Joseph County
Director: Lionel E. Dorfman, MD
Staff: Rose Heald

Sanilac County
Director: Kenneth B. Herrington, MD
Staff: Sherry Fent

Schoolcraft County
Director: Carl F. Hammerstrom, MD
Staff: David Fox

Shiawassee County
Director: Cathy O. Blight, MD
Staff: John Richards

Tuscola County
Director: Jack L. Barry, MD
Staff: John Richards

Van Buren County
Directors: David J. Millard, MD
B. David Wilson, MD
Staff: Debbie Zannoth

Washtenaw County
Directors: Fred E. Patterson, MD
Marguerite Shearer, MD
Staff: Linda Munson

Wayne County
Directors: Robert W. Black, MD
Gilbert B. Bluhm, MD
Henry M. Domzalski, MD
Richard P. Horsch, MD
W. Peter McCabe, MD
Charles C. Vincent, MD
Frank B. Walker, MD
Staff: William Madigan

Wexford-Missaukee Counties
Director: John W. Hall, MD
Staff: Sherry Wellman

MSMS COMMITTEES address many issues

The 50 MSMS committees and task forces provide a platform for addressing issues ranging from aging to medical licensure and discipline. To effectively address such a wide range of issues, MSMS committees rely heavily upon member input. MSMS encourages as many different physicians as possible from every geographical area.

Committee appointments are awarded annually at the MSMS Mid-summer Board of Directors Meeting held in July. Members are selected from a pool of applicants who have been nominated by current committee members, MSMS section officers and specialty and component society leaders. Committee appointments are two-year terms, with new appointments taking place annually.

The first step toward obtaining a position, and the most difficult, is determining which committee (or committees) interests you most. A complete list of MSMS committees and task forces begins on this page. Each committee listing includes a brief statement of goals.

Members interested in serving on a committee must be appointed by the MSMS Board of Directors. Simply contact a current committee member, MSMS section leader, MSMS Board member, your county medical society or specialty society, or contact MSMS headquarters and request a recommendation. Each January MSMS begins seeking recommendations for committee appointments for the coming year. So now is a good time to start thinking about what committee you would like to join.

For more information on any of the MSMS committees, contact Katie Brewbaker at MSMS.

Committee on Aging

This Committee provides physicians with an overview of the medical, social, and psychological needs of the aged patient. Activities include examining the health status of the older patient, advocating preventive medicine programs, discussing Medicare financing, and exploring long term care options for the elderly. The Committee works with many community organizations and the State Office of Services for the Aging.

James G. O'Brien, MD
East Lansing
Chairman

Harvey M. Andre, MD, Grand Rapids
Archie Bedell, MD, St. Clair Shores
Frank B. Blumenthal, MD, Detroit
Bernard Chodorkoff, MD, Drayton Plains
Diane A. Culik, MD, Grosse Pointe Farms
Willis Dixon, MD, Grand Rapids
Phillip M. Green, MD, Kalamazoo
Kenneth B. Herrington, MD, Bad Axe
J. Christopher Hough, MD, Midland
Daya P. Joshi, MD, Livonia
Raphael J. Kiel, MD, Detroit
Richard A. Knecht, MD, Petoskey
Daniel E. Leb, MD, Bloomfield Hills
Brooker L. Masters, MD, Fremont
Carl H. Moberg, MD, Grand Rapids
Kenneth K. Newton, MD, St. Clair Shores
Rakesh N. Saxena, MD, Alma
Ashok R. Sonnad, MD, Vestaburg
Robert J. Toteff, MD, Troy
Marcelle R. Salib, MD, Livonia
Russell E. Holmes, MD, Consultant, Lansing
Thomas J. Northey, Consultant, Lansing
John Peterson, PhD, Consultant, Lansing
James R. Tarrant, Consultant, East Lansing
F. B. "Tom" Plasman, Staff

Task Force on AIDS Education

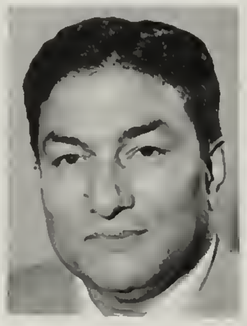
This Task Force develops strategies for educating physicians about AIDS and coordinates MSMS efforts in physician and public education with those of the Michigan Department of Public Health.

Frederick W. Bryant, MD
Royal Oak
Chairman

Robert D. Allaben, MD, Detroit
Isak O. Berker, MD, Lapeer

Addy

Adelman


Ahmad

Aiken

Barry

Lawrence R. Crane, MD, Grosse Pointe Park
David S. Davenport, MD, Kalamazoo
David R. Dobbie, MD, Grand Rapids
William E. Dougan, MD, Detroit
John F. Fennessey, MD, Grosse Pointe
Evelyn J. Fisher, MD, Detroit
Edgar J. Geist, Jr., MD, Rochester Hills
Ruben D. Legaspi, MD, Roseville
Douglas A. Mack, MD, Grand Rapids
David B. Martin, MD, Traverse City
Kenneth K. Newton, MD, St. Clair Shores
David R. Rovner, MD, East Lansing
E. Remington Sprague, MD, Muskegon
Richard M. Tooker, MD, Kalamazoo
Lisa M. Strother, Staff

Steering Committee on Program to Assist Impaired Physicians

This Steering Committee provides assistance, through its medical director and a statewide network of volunteer physicians, to physicians who have problems related to emotional illness, alcoholism, chemical dependency, and physical impairment, and serves as the advisory body to the Physicians Recovery Network. Education and research toward prevention, case finding, and intervention are major components of the program.

James L. Fenton, MD
Bay City
Chairman

Robert Niccolini, MD, Vice-chairman, Detroit
Frederick W. Bald, MD, Kalamazoo
Norman J. Bolton, MD, Detroit
Michael F. Boyle, DO, West Bloomfield
Sander J. Breiner, MD, Birmingham
Thomas A. Bruce, MD, Battle Creek
Samuel R. Dismond, MD, Flint
Allan M. Ebert, DO, Flint
Morris Fineman, DO, Livonia
James P. Gallagher, MD, Allen Park
Charles F. Gehrke, MD, Ypsilanti
George P. Harris, MD, Saginaw
Thomas L. Haynes, MD, Grand Rapids
Robert H. Hydrick, MD, Grand Rapids
Beverly Jensen, Grand Rapids
Bobbe J. Kelley, DO, West Bloomfield
Ray F. Kiefer, MD, Muskegon
William J. Kube, MD, Kalamazoo
Douglas W. MacDonald, MD, Oxford
Jeffrey A. Meer, MD, Southfield
Richard A. Morin, MD, Ann Arbor
Eugene Sands, DO, West Bloomfield
Hernan S. Schmidt, MD, Battle Creek
Gerald A. Sieggreen, MD, Saginaw
Justin L. Sleight, MD, Lansing
J. G. Steigerwald, DO, Traverse City
Gerald A. Vander Voord, MD, East Lansing
Francis V. Viola, III, MD, Dearborn
Max W. Warren, MD, Southfield
Michael L. Zarr, MD, Flint
Richard D. Weber, Consultant, Detroit
Katie Brewbaker, Staff

Committee on Awards

This Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Billy Ben Baumann, MD
Pontiac
Chairman

Henry M. Domzalski, MD, Detroit
Thomas C. Payne, MD, Lansing
Katie Brewbaker, Staff

Committee on Bioethics

This Committee considers questions about scientific, medical, moral, ethical, and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and, therefore, MSMS.

Howard A. Brody, MD
East Lansing
Chairman

Isak O. Berker, MD, Lapeer
Frederick W. Bryant, MD, Troy
Michael J. Brennan, MD, Detroit
John R. Caldwell, MD, Birmingham
Ralph D. Cushing, MD, Grosse Pointe
Betty Drew, Bloomfield Hills
Patrick J. Droste, MD, Grand Rapids
Thomas E. Elkins, MD, Ann Arbor
Reginald W. Harnett, MD, Taylor
John V. Hartline, MD, Kalamazoo
Francis Horvath, MD, Lansing
Philip M. Margolis, MD, Ann Arbor
Richard J. McMurray, MD, Flint
Butchi B. Paidipaty, MD, Livonia
Evan J. Reinders, MD, Muskegon
Kenneth E. Rowe, MD, Hancock
Emiliana San Diego, Grand Rapids
Charles A. Thompson, MD, Flint
Kornelius Van Goor, MD, Grand Rapids
Peter D. Van Vliet, MD, Grand Rapids
William B. Weil, MD, East Lansing
Peter A. Levine, Consultant, Flint
Sherry N. Wellman, Staff

Liaison Committee with Blue Cross Blue Shield of Michigan

This Liaison Committee serves as a communication link to assist individual physicians in obtaining information concerning Blue Cross Blue Shield of Michigan's policies and procedures, and provides input to aid in the resolution of problems which may arise. The Committee also considers and provides input on major policy and professional issues related to BCBSM.

Susan H. Adelman, MD
Detroit
Chairman

Billy Ben Baumann, MD, Pontiac
Robert W. Black, MD, Detroit
Gilbert B. Bluhm, MD, Southfield
Donald K. Crandall, MD, Muskegon
David A. Detrisac, MD, East Lansing
Henry M. Domzalski, MD, Detroit
William B. Jensen, Jr., MD, Grand Rapids
Gary L. Maynard, MD, Kalamazoo
Donald B. Muenk, MD, Warren
Richard L. Rapport, MD, Flint
Rahul B. Sangal, MD, Troy
Arthur A. Ulmer, MD, Grosse Pointe Shores
Robert T. Ortwein, Staff

Advisory Committee on Communications and Professional Relations

This Committee develops and oversees all public relations and public service activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Henry M. Domzalski, MD
Detroit
Chairman

Robert C. Arends, MD, Birmingham
Gilbert B. Bluhm, MD, Southfield
Carol Brown, Spring Lake
Frederick B. Brown, MD, Muskegon
Charles D. Bukrey, MD, Grand Rapids
Don G. Davis, MD, East Lansing
Pat Dolan, Kalamazoo
Fereshteh Fahimi, MD, Lansing
Clyde R. Flory, MD, Lansing
George C. Hill, MD, Ferndale
Gary K. Johnson, MD, Flint
Shaukat A. Khan, MD, Grand Rapids
Raymond R. Komray, MD, Muskegon
Fred E. Patterson, MD, Jackson
B. L. Pederson, MD, Bay City
W. Archibald Piper, MD, Flint
D. V. Ramana, MD, Lapeer
M. Gary Robertson, MD, Grand Haven
Jerry H. Rosenberg, MD, Southfield
Sherry N. Wellman, Staff

Committee on Constitution and Bylaws

This Standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action

Continued on page 26

Baumann

Bluhm

Brody

Bryant

Domzalski

Continued from previous page

by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

James E. McGillicuddy, MD
Lansing
Chairman

Robert H. Evans, MD, Sturgis
Angel Farina, MD, Garden City
Jack D. Gift, MD, Jackson
Thomas F. Higby, MD, Fowlerville
John H. McLaughlin, MD, Birmingham
William E. Madigan, ex officio, East Lansing
Richard D. Weber, Consultant, Detroit
Vada L. Davis, Staff

Committee on CME Accreditation

This Committee assures that quality CME activities are available to Michigan physicians through review, evaluation, and accreditation of Category 1 continuing medical education providers in the state.

Donald J. Aiken, MD
Okemos
Chairman

Gail I. Bank, PhD, Detroit
Ralph L. Brandt, MD, Ann Arbor
James C. Breneman, MD, Galesburg
Ernest M. Hammel, PhD, Rochester
Roland G. Hiss, MD, Ann Arbor
Van O. Keeler, MD, Kalamazoo
Mark D. Kolins, MD, Grosse Pointe Farms
Bryant W. Pierce, MD, Grand Rapids
Robert K. Richards, PhD, Grand Rapids
Victor V. Rozas, MD, Alma
Robert L. Tupper, MD, Grand Rapids
Richard F. Willis, MD, Alpena
Ralph M. Wynn, MD, Bloomfield Hills
Charles L. Zeller, MD, Kalamazoo
Thomas J. DeKornfeld, MD, Consultant, Lansing
Katie Brewbaker, Staff

Committee on CME Programming

This Committee develops, conducts, and supervises Category 1 programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to jointly sponsor programs which meet the CME criteria for Category 1.

David R. Rovner, MD
East Lansing
Chairman

John R. Addy, MD, Lansing
Patrick C. Alguire, MD, East Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Troy
Richard E. Dean, MD, East Lansing
Clyde R. Flory, MD, Lansing
Michael J. Giacalone, Jr., MD, Flint
Perry W. Greene, Jr., MD, Grand Rapids
Michael Iacobellis, MD, Allen Park
Steven E. Minnick, MD, Detroit
John B. O'Donnell, MD, Grand Rapids
Samir M. Ragheb, MD, Warren
Shirley Robertson, MD, Mason
George L. Royer, MD, Kalamazoo
Donald J. Scholten, MD, Grand Rapids
Joan C. Stryker, MD, Detroit
S. B. Zampani, MD, Livonia
James R. Tarrant, Consultant, East Lansing
Sherry L. Fent, Staff

Liaison Committee with Corporate Medical Directors

This Liaison Committee meets with medical directors of corporations to discuss common interests, recommend appropriate courses of action, and consider occupational safety issues.

Richard H. Gascoigne, MD
Adrian
Chairman

Lionel E. Dorfman, MD, Battle Creek
David W. Hills, MD, Benton Harbor
Robert G. Hylland, MD, Muskegon
David Jacknow, MD, Bloomfield Hills
Robert A. Janke, MD, Kalamazoo
George A. Kling, MD, Grosse Pointe Farms
Sanganur V. Mahadevan, MD, Allen Park
Steven E. Newman, MD, Southfield
Robert T. Nolta, MD, Warren
Robert S. Rhodes, MD, Ypsilanti
Elias A. Shaptini, MD, Detroit
Dean T. Smith, MD, Grand Rapids
John H. Triebwasser, MD, Dearborn
R. J. Van Valkenburg, MD, Battle Creek
Clinton W. Wilson, MD, Benton Harbor
David K. Fox, Staff

Committee on Federal Legislation

This Committee monitors and influences federal legislation, and rules and regulations in conjunction with the AMA Washington office.

Thomas E. Stone, MD
Muskegon
Chairman

Jack L. Barry, MD, Bay City
Robert D. Burton, MD, Grand Rapids
William E. Madigan, ex officio, East Lansing
Appa Rao Mukkamala, MD, Flint
K. S. Rajan, MD, Lapeer
Louis R. Zako, MD, Dearborn Heights
Kevin A. Kelly, Staff

Governing Council, Graduates of Foreign Medical Schools Section

Busharat Ahmad, MD
Marquette
Chairman

Krishna K. Sawhney, MD, Vice Chairman, Taylor
Allan C. D. Brown, MD, Ann Arbor
Jose L. Evangelista, MD, Livonia
Vicente C. Gracias, MD, Grand Rapids
Byung S. Lee, MD, Mt. Clemens
Samir R. Yahia, MD, Detroit
Judith E. Marr, Staff

Governing Council, Hospital Medical Staff Section

Gary D. Maynard, MD
Kalamazoo
Chairman

Devendra Sharma, MD, Vice Chairman, Tawas City
Harry L. Doerr, MD, Southfield
Peter A. Duhamel, MD, Rochester
Gerhard C. Endler, MD, Detroit
John A. Rupke, MD, Grand Rapids
Krishna K. Sawhney, MD, Taylor
F. B. "Tom" Plasman, Staff

Governing Council, Medical Student Section

Safa Kassab
WSU
Chairman

Pino Colone, MSU
Charles Desibow, U-M
Jay Fischer, WSU
Brett Gerber, U-M
Rick Imirowicz, WSU
Jan Johnson, WSU
Kim Koons, U-M
Par Rihal, WSU
Laurence Truman, WSU
Karen Vanderwall, WSU
Steve Weisman, MSU
Jerome L. Yaklic, WSU
Deborah Zannoth, Staff

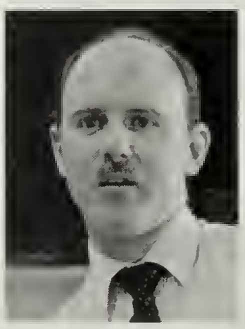
Governing Council, Resident Physician Section

A. Bradley Eisenbrey, MD
Grosse Pointe Woods
Chairman

Alan B. Brown, MD, Ann Arbor
Angela D. DeSantis, MD, Dearborn
Brian F. Jewell, MD, Ferndale
Adil M. Karamali, MD, Dearborn
James V. Palazzolo, MD, Lincoln Park
Rose B. Heald, Staff

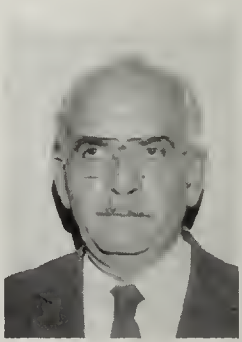
Donn

Duhamel



Eisenbrey

Fenton



Greene

Governing Council, Young Physicians Section

Richard A. Stone, MD
Mt. Clemens
Chairman

Tama D. Abel, MD, Ann Arbor
Thomas J. Archambeau, MD, Lansing
Thomas M. George, MD, Kalamazoo
Ray F. Kiefer, MD, Muskegon
Mark D. Kolins, MD, Grosse Pointe
Dean G. Sienko, MD, Lansing
Linda J. Munson, Staff

Advisory Committee on Health Care Policy

This Committee recommends MSMS policy on health planning. It encourages physician involvement in state health planning activities and in state health policy activities.

Fred E. Patterson, MD
Jackson
Chairman

Jeffrey D. Band, MD, Royal Oak
Robert B. Carbeck, MD, Ann Arbor
Thomas F. Curtin, MD, East Jordan
James R. Dolan, MD, Kalamazoo
Gregory J. Forzley, MD, Grand Rapids
George R. Gerber, MD, Detroit
Denise G. K. Gray, MD, Detroit
John V. Hartline, MD, Kalamazoo
D. Bonta Hiscoe, MD, Lansing
Samuel D. Indenbaum, MD, Birmingham
Martin F. Jones, MD, Lansing
John C. Kirkpatrick, MD, Sturgis
Sung G. Lee, MD, East Lansing
Steven E. Newman, MD, Southfield
Harold Perry, MD, Detroit
Kenneth J. Ray, MD, Trenton
Charles L. Shabino, MD, Kalamazoo
Marguerite R. Shearer, MD, Dexter
Donald C. Smith, MD, Ann Arbor
Edward J. Snell, MD, Grand Rapids
William C. Thompson, MD, Dearborn
Robert M. Williams, MD, Traverse City
Mary Anne Ford, Staff

Task Force on Health Care for the Uninsured

This Task Force reviews legislative and administrative proposals relative to health care for the uninsured and analyzes their impact on physicians, facilitates the involvement of MSMS and its members in pilot projects or volunteer efforts, and formally interacts with other organizations addressing the problem of health care for the uninsured, including the Governor's Task Force on Health Care for the Uninsured.

Marguerite R. Shearer, MD
Dexter
Chairman

H. Richard Henderson, MD, Farmington Hills
Samuel D. Indenbaum, MD, Detroit
Robert P. Lorenz, MD, Royal Oak
Daniel S. Mazzuchi, MD, Marquette
Jack M. Stack, MD, Alma
Charles A. Thompson, MD, Flint
Mary Anne Ford, Staff

Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal, perinatal, and neonatal health to discuss mutual problems and share ideas. It works in close cooperation with state agencies and medical specialty organizations.

Robert P. Lorenz, MD
Royal Oak
Chairman

John R. Addy, MD, Lansing
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
Sidney F. Bottoms, MD, Detroit
David R. Calver, MD, Bloomfield Hills
Ralph A. Cram, MD, Albion
Preston V. Dilts, MD, Ann Arbor
Steven M. Donn, MD, Ann Arbor
William E. Dougan, MD, Detroit
Robert W. Dustin, MD, Dearborn
Gerhard C. Endler, MD, Grosse Pointe Woods
John D. Fachnie, MD, Birmingham
Alan M. Gardner, MD, Ann Arbor
James W. Gell, MD, Bloomfield Hills
John V. Hartline, MD, Kalamazoo
Robert H. Hayashi, MD, Ann Arbor
John Hebert, MD, Flint
Richard P. Horsch, MD, Detroit
Lloyd A. Kammeraad, MD, Grand Rapids
Douglas G. Kinne, MD, Petoskey
Mary J. Kokosky, MD, Dearborn
Chang Y. Lee, MD, Flint
Francis A. Locke, MD, Adrian
M. Jeffrey Maisels, MD, Royal Oak
Federico G. Mariona, MD, Dearborn
S. Gene McNeeley, MD, Ann Arbor
Joseph S. Moore, MD, Grand Rapids
Ronald A. Nichols, MD, Lansing
B. L. Pederson, MD, Bay City
Jose A. Peralta, MD, Rochester
Roger W. Postmus, MD, Ypsilanti
Donald F. Silver, MD, Franklin
Errol I. Soskolne, MD, Ann Arbor
David B. Schwartz, MD, Detroit
Stephen L. Segrave-Daly, MD, Fremont
Arthur A. Ulmer, MD, Grosse Pointe Shores
Paul T. von Oeyen, MD, Royal Oak
Earl R. Williams, MD, Grand Rapids
Melisande G. Womack, MD, Detroit
George W. Russian, DO, Consultant, Okemos
C. Maureen Sander, MD, Consultant, East Lansing
(Consultants designated by MDPH also serve on this Committee)
Katie Brewbaker, Staff

Medicaid Liaison Committee

This Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Cecil R. Jonas, MD
Detroit
Chairman

Waheed Akbar, MD, Saginaw
Charles G. Artinian, MD, Bloomfield Hills
Rolland E. Bethards, MD, Lansing
Thomas M. Flake, MD, West Bloomfield
Alma R. George, MD, Detroit
H. Richard Henderson, MD, Livonia
William E. Hill, MD, Pontiac
Harm Kraai, MD, Pontiac
Robert L. Leeser, MD, Charlotte
David B. Martin, MD, Traverse City
Michael J. Parks, MD, South Haven
Thomas C. Payne, MD, Lansing
Allen F. Turcke, MD, Flint
Lawrence R. Weschky, MD, Sturgis
Daniel J. Wilhelm, MD, Port Huron
Gilbert B. Bluhm, MD, Consultant, Southfield
Donald K. Crandall, MD, Consultant, Muskegon
Mary Anne Ford, Staff

Advisory Committee on Medical Economics

This Advisory Committee assists MSMS in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Gilbert B. Bluhm, MD
Southfield
Chairman

Asir U. Ahmad, MD, Pontiac
Jack L. Barry, MD, Saginaw
Steven R. Baker, MD, Grand Rapids
Joseph J. Berke, MD, Detroit
M. Joseph Bowler, MD, Kalamazoo
Frederick B. Brown, MD, Muskegon
Robert B. Carbeck, MD, Ann Arbor
Frank E. Check, Jr., MD, Detroit

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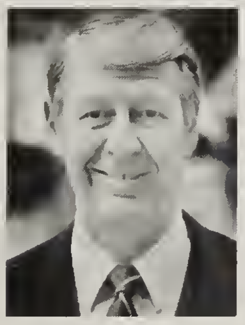
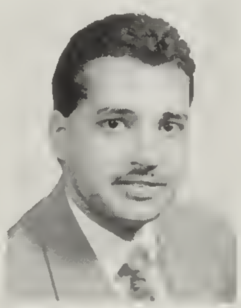

Gascoigne

Holly

Jonas


Kassab

Kahkonen

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Hugh G. Deery, MD, Petoskey
Jay W. Eastman, MD, Birmingham
Charles A. Easton, MD, Tawas City
David B. Edgar, MD, Grand Rapids
Erwin J. Haas, MD, Grand Rapids
Floyd G. Goodman, MD, East Lansing
Harvey W. Halberstadt, MD, Birmingham
Edward G. Jankowski, MD, Warren
Margaret E. Jones, MD, East Lansing
Daya P. Joshi, MD, Livonia
Ruben S. Kurnetz, MD, Birmingham
Stanley H. Levy, MD, Detroit
Appa Rao Mukkamala, MD, Flint
Richard L. Rapport, MD, Flint
Edward J. Rutkowski, MD, Traverse City
Fred R. Severyn, MD, Detroit
Charles G. Todoroff, MD, Dearborn
Frederick W. Van Duyne, MD, Flint
Joseph J. Weiss, MD, Huntington Woods
Robert T. Ortwein, Staff

Committee on Medical Licensure and Discipline

This Committee serves as a liaison to the Michigan Department of Licensing and Regulations and the Michigan Board of Medicine, and seeks and supports measures that will promote a fully effective Board of Medicine.

Rhoda M. Powsner, MD
Dearborn
Chairman

Yousef B. Bishai, MD, Warren
Gilbert B. Bluhm, MD, Southfield
Frederick B. Brown, MD, Muskegon
Ricardo Chalela, MD, Washington
Jerry Drake, MD, Dearborn
Ben R. Fajardo, MD, Mt. Clemens
James L. Fenton, MD, Bay City
Daniel X. Garcia, MD, Battle Creek
Robert D. Gibson, MD, Newberry
Martin F. Hoffmann, MD, Mattawan
Shivappa V. Hulbanni, MD, Livonia
David G. Jaimovich, MD, Kalamazoo
William J. Kube, MD, Kalamazoo
Donald H. Kuiper, MD, Lansing
Devinder K. Mahajan, MD, Taylor
James A. O'Neill, MD, Clarkston
Butchi B. Paidipaty, MD, Livonia
B. L. Pederson, MD, Bay City
John C. Rienstra, MD, Grand Rapids
Arthur Rose, MD, Southfield
Larry J. Sell, MD, Detroit
Vishnu K. Sharma, MD, Lapeer
Orlando S. Sison, MD, Detroit
Siavosh Varjavadni, MD, Flint
Robert A. Teitge, MD, Warren
Vernon C. Urich, MD, Flint
Theordore S. Vanderveen, MD, Grand Haven
Scott W. Woods, MD, Ypsilanti
John A. Ingold, MD, Consultant, Royal Oak
Thomas M. Wolff, Staff

Committee on Membership Recruitment and Retention

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors, and conducts personal recruiting efforts when needed.

Dorothy Kahkonen, MD
Detroit
Chairman

Waheed Akbar, MD, Saginaw
Carol Brown, Spring Lake
R. Jack Chase, MD, Grand Rapids
Karl J. Edelman, MD, Ann Arbor
Angel Farina, MD, Garden City
Robert G. Fawcett, MD, Petoskey
Lorenz P. Kielhorn, MD, Jackson
Edward D. Lanigan, MD, Lansing
Joyce Mann, Grand Rapids
Lee Marmion, MD, Grand Rapids
Judith L. Meyer, MD, Grand Rapids
Michael S. Mittell, MD, Lansing
Kevin T. O'Donnell, MD, Southfield
Earl J. Rudner, MD, Southfield
Samir R. Yahia, MD, Detroit
Louis R. Zako, MD, Dearborn Heights
Robert D. Hahn, Consultant, Detroit
Margo Hoornstra, Consultant, Lansing
Peter A. Levin, Consultant, Flint
William McClimans, Consultant, Grand Rapids
Mary Sue Meyer, Consultant, Birmingham
Sallie Schiel, Consultant, Ann Arbor
Deborah Zamoth, Staff

Liaison Committee with Michigan Department of Public Health

This Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

Douglas A. Mack, MD
Grand Rapids
Chairman

E. Joseph Alberding, MD, Portage
Elaine L. Atallah, MD, Farmington Hills
Bradley T. Barnes, MD, Rochester Hills
Lawrence R. Crane, MD, Grosse Pointe Park
Evelyn Dykewicz, Flint
William E. Hill, MD, Pontiac
Linda S. Hotchkiss, MD, Detroit
Mary L. Jackson-Hammond, MD, Detroit
Ronald L. Krome, MD, Royal Oak
Donald W. Lawrenchuk, MD, Livonia
Vivian M. Lewis, MD, Flint
Kenneth D. McClatchey, MD, Ann Arbor
David C. Nolan, MD, White Cloud
John G. O'Rourke, MD, Jackson
Frank L. Pettinga, MD, Muskegon
Kenneth E. Rowe, MD, Hancock
Richard M. Tooker, MD, Kalamazoo
Keats K. Vining, MD, Grand Rapids
Mary Anne Ford, Staff

Michigan Doctors Political Action Committee, Board of Directors

Peter A. Duhamel, MD
Rochester
Chairman

Larry J. Andreini, MD, Escanaba
Jack L. Barry, MD, Bay City
Jill Berglund, Kalamazoo
Joseph J. Berke, MD, Detroit
Donald G. Blain, MD, Mt. Clemens
Cathy O. Blight, MD, Flint
Donna Chase, Grand Rapids
William D. Doebler, MD, Holland
Lionel E. Dorfman, MD, Battle Creek
Domenic R. Federico, MD, Grand Rapids
John A. Feemster, MD, Southfield
Richard H. Gascoigne, MD, Adrian
Richard P. Heuschele, MD, Saginaw
Cecil R. Jonas, MD, Detroit
Mark D. Kolins, MD, Grosse Pointe Farms
Robert E. Mengebier, MD, Petoskey
Marsha Milburn, MD, Lansing
Fred E. Patterson, MD, Jackson
Robert E. Paxton, MD, Fremont
Thomas C. Payne, MD, East Lansing
Mitchell A. Rinek, MD, Okemos
Krishna K. Sawhney, MD, Taylor
Marguerite R. Shearer, MD, Dexter
Gary S. Smith, MD, Midland
Thomas E. Stone, MD, Muskegon
Floyd S. Tukel, MD, Dearborn
B. David Wilson, MD, Kalamazoo
B. J. Woodley, MD, Trenton
Louis R. Zako, MD, Dearborn Heights
Daniel R. Farhat, Staff

Liaison Committee with Michigan Medical Arbitration System

This Committee serves as a liaison between MSMS and the Michigan Medical Arbitration System and works to promote the use of arbitration in Michigan.

Rhoda M. Powsner, MD
Dearborn
Chairman

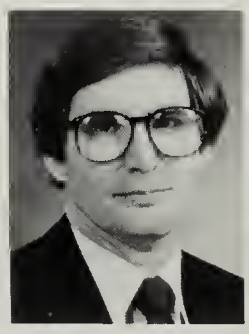
Gregory A. Bohn, MD, Muskegon
John W. Hall, MD, Petoskey
Ivan R. Landan, MD, St. Joseph
David W. Learned, MD, Ann Arbor

Lorenz

Mack

Maynard

McGillicuddy


Nagle

O'Brien

Gerald H. Mandell, MD, Detroit
Robert J. Toteff, MD, Troy
Joseph J. Weiss, MD, Huntington Woods
Mary Anne Ford, Staff

Liaison Committee with Michigan Peer Review Organization (MPRO)

This Liaison Committee monitors the activities of the federal peer review organization of Michigan (MPRO), provides policy input to MPRO on medical and operational issues, meets with MPRO representatives to discuss matters of mutual interest, and assists individual physicians in dealing with problems or concerns they may have with MPRO.

Robert C. Packer, MD
Muskegon
Chairman

Joseph A. Arena, MD, Birmingham
Gerhard C. Endler, MD, Grosse Pointe Woods
W. Rodney Flanary, MD, Grand Rapids
Peter E. Fujiwara, MD, Bay City
Ronald H. Horowitz, MD, East Lansing
David K. Johnson, MD, Lansing
Omar Kadro, MD, Royal Oak
Donald H. Kuiper, MD, Lansing
Ivan R. Landan, MD, St. Joseph
Gary D. Maynard, MD, Kalamazoo
Marsha Milburn, MD, Lansing
Linda D. Norrell, MD, Flint
D. V. Ramana, MD, Lapeer
Myer H. Roszler, MD, Detroit
Marguerite R. Shearer, MD, Dexter
F. Remington Sprague, MD, Muskegon
Gordon F. Van Otteren, MD, Grand Rapids
Joseph J. Weiss, MD, Livonia
Francis M. Wilson, MD, Grosse Pointe Farms
Samir R. Yahia, MD, Detroit
F. B. "Tom" Plasman, Staff

Committee on MSMS Archives

This Committee researches and retains a record of Michigan medical history so it will be preserved for future generations.

Frederick W. Bryant, MD
Troy
Chairman

Ned I. Chalet, MD, Detroit
William E. Madigan, ex officio, East Lansing
David K. Fox, Consultant, East Lansing
F. B. "Tom" Plasman, Consultant, East Lansing
Katie Brewbaker, Staff

MSMS/Michigan Hospital Association Liaison Committee

This formal Liaison Committee is composed of designed leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

Susan H. Adelman, MD
Detroit
President-elect

Jack L. Barry, MD, Bay City, Vice-chairman of the Board
Frederick W. Bryant, MD, Troy, Immediate Past-president
William E. Madigan, East Lansing, Executive Director
Gary D. Maynard, MD, Kalamazoo, Chairman, Hospital Medical Staff Section Governing Council
Robert E. Paxton, MD, Fremont, President
Frank B. Walker, MD, Grosse Pointe Farms, Chairman of the Board
Kevin A. Kelly, Staff

Committee on MSMS Policy Manual

This Committee reviews actions of the House of Delegates and incorporates any policy decisions into the Policy Manual of MSMS.

Frederick W. Bryant, MD
Troy
Chairman

Robert D. Allaben, MD, Detroit
Henry M. Domzalski, MD, Detroit
James L. Fenton, MD, Bay City
Thomas E. Stone, MD, Muskegon
Vada L. Davis, Staff

Board of Directors, Physicians Service Group, Inc.

Billy Ben Baumann, MD
Pontiac
President

Frederick W. Bryant, MD, Troy
Mark Campbell, MD, Grand Rapids
Henry M. Domzalski, MD, Detroit
Elizabeth A. Hutchinson, MD, Lansing
William E. Madigan, East Lansing
John A. Richards, East Lansing
Allen F. Turcke, MD, Flint

Advisory Committee on Office Automation

This Committee advises staff in its plan for automation of MSMS office operations.

Jack L. Barry, MD
Bay City
Chairman

Billy Ben Baumann, MD, Pontiac
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Planning Committee for Michigan Conference on Maternal and Perinatal Health

This Planning Committee plans and implements the Category 1 CME program for the annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several other participating organizations.

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Co-chairman

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Suzanne Shelton, RN, Kalamazoo
Paul T. von Oeyen, MD, Royal Oak
Daniel J. Wilhelm, MD, Port Huron
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Planning Committee for MSMS Annual Scientific Meeeting

This Planning Committee, under the guidance of the Committee on CME Programming, plans and presents Category 1 Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

Conrad E. Nagle, MD
Troy
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Frederick W. Bryant, MD, Troy
Miriam S. Daly, MD, Albion

Continued on page 30

Packer

Patterson

Powsner

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Continued from previous page

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Task Force on Professional Liability

This Task Force reviews the professional liability climate in Michigan and the nation, is familiar with proposed reforms, and recommends appropriate legislative or other improvements.

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Task Force on Rural Health Care

This Task Force gathers information on the increasing challenges of change occurring in rural health care and helps physicians make the necessary practice changes so that they may continue to provide quality health care to rural Michigan residents.

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Committee of Specialty Society Presidents

This Committee provides for regular communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concerns except scientific or clinical medicine.

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Committee on Sports Medicine

This Committee develops and presents a conference aimed at physicians and others with an interest in sports medicine. It also provides sports medicine information and medical evaluation of sports rules when requested by the Michigan High School Athletic Association, Inc.

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This Liaison Committee promotes interprofessional cooperation, helps mediate problems between physicians and attorneys, and encourages communication on topics of mutual interest.

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This Committee monitors and influences Michigan legislation through the legislative process, and monitors and responds to Michigan government rules and regulations as they are promulgated.

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Committee on Concerns of Women Physicians

This Committee explores ways to encourage the participation and leadership involvement of women physicians in organized medicine.

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Fereshteh Fahimi, MD, Lansing
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WHOM TO CALL AT MSMS HEADQUARTERS

EXECUTIVE DIRECTOR: WILLIAM E. MADIGAN
ASSISTANT DIRECTOR: KEVIN A. KELLY

The individuals listed at right are a very integral part of the Michigan State Medical Society - they are the staff. The 55 members of the staff provide a wealth of information and assistance every day to MSMS members who have questions and want answers.

Here are just a few of the questions MSMS has received and answered: "Medicare has not sent a payment in three months and I have provided over $60,000 worth of treatment. Who can I talk to at BCBSM about this problem?" "I neglected to renew my license and I am scheduled for surgery tomorrow. I cannot reach the Department of Licensing and Regulation. Can you help me?" Staff was able to provide assistance to these physicians and stands ready to assist the membership everyday.

Do not forget that the MSMS staff members listed at right can help you through a bureaucratic maze, give you the most complete information about the current health care delivery system, or simply provide you with directions to the MSMS building. If you have questions, we encourage you to pick up the phone and call us.

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Accreditation	Katie Brewbaker
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Membership Recruitment	Deborah Zannoth
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Michigan Association of Medical Education	Viola Heins
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medicine (MSMS Journal)	Judy Marr, Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
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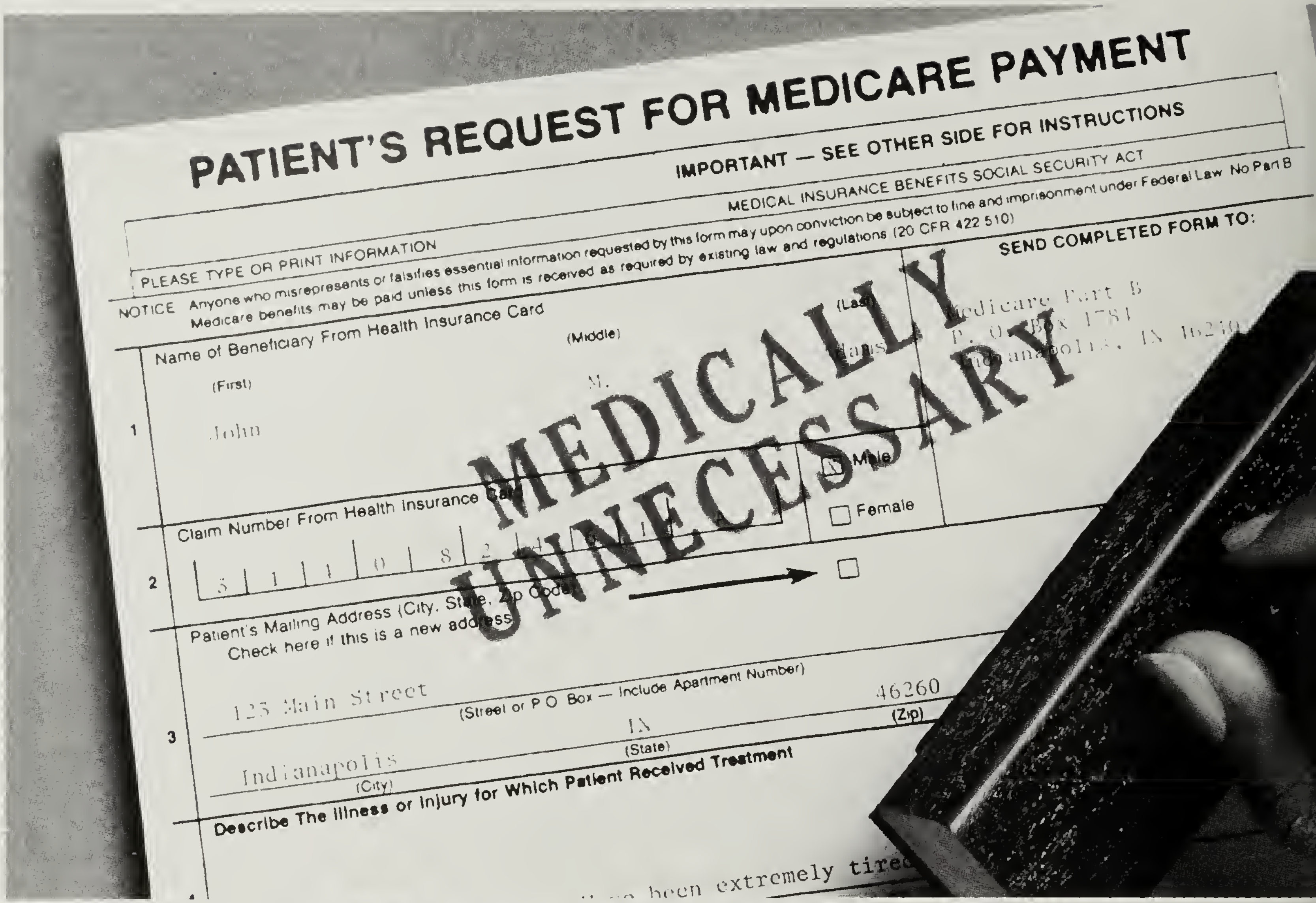
MSMS Travel Programs	Donna Farougi
Physicians Recovery Network	Katie Brewbaker
Peer Review Organization of Michigan, Inc. (PROM)	John Richards, Barbara Banks, RN
Physician Legislative Network	Dan Farhat, Tom Wolff
Physician Service Group, Inc.	John Richards
Practice Management	John Richards, Amy Fistler
Professional Liability Insurance	Richard Campau
Public Health Liaison	Mary Anne Ford
Public Relations	Sherry Wellman
Risk Management	Richard Campau
Specialty Societies	Donna Farougi

1989 MSMS TOP ISSUES

1. Professional Liability:	MSMS is lobbying for protection of pension and profit-sharing plans in the event of bankruptcy proceedings. Speaker-elect Lewis Dodak has promised that pension protection legislation will be a priority in the 1989 session. MSMS also is exploring non-tort alternatives such as: — An at-fault system which would pay compensible claims similar to workers' compensation payments. MSMS is joined in this effort by the Michigan Hospital Association. — A program similar to the Swedish patient compensation, risk management and physician discipline systems. — Either mandatory arbitration or reduced health insurance premiums for physicians using the Michigan arbitration system. — A "bad baby" fund similar to the recently-enacted Virginia plan which helps compensate for birth-related injuries regardless of cause. MSMS is reviewing the plan as part of a demonstration project for the Health Policy Agenda for the American People. — MSMS will continue to seek tort reform, pressing for removal of the exceptions to the cap on non-economic damages, further improvement in the statute of limitations, stricter qualifications for expert witnesses, evaluation of the modification of the joint and several rule, and countersuit legislation.
2. Integrated Licensure:	MSMS will lead in developing a new physician discipline structure similar to that of the State Bar.
3. Risk Management:	MSMS will inform Michigan physicians of how to minimize risks of lawsuits and how to take advantage of premium reductions for attending risk management seminars.
4. AIDS:	MSMS and the State Bar are developing a series of policy statements to protect physicians in management of AIDS patients. The policies will go to the legislature in early January. MSMS also leads in AIDS provider education efforts through a Michigan Department of Public Health grant.
5. Quality Health Care:	MSMS will continue to emphasize quality health care in the face of cost containment, in dealings with the new Governor's Task Force on Managing Health Care Costs, and in a joint effort with the Michigan Health Data Corporation and Michigan Hospital Association to develop a quality institute.
6. Physician Education:	MSMS will continue to provide continuing medical education, updates on preserving quality of care and on improving practice productivity.
7. Hospital Medical Staffs:	MSMS leaders will work to address nearly 20 hospital medical staffs at their general meetings in 1989. This will continue the "Physicians' Issue Presentations" initiated in 1988 which complement activities of the MSMS Hospital Medical Staff Section.
8. Third Party Payers:	MSMS will continue its advocacy efforts on behalf of Michigan physicians with Blue Cross Blue Shield of Michigan, Medicaid, Medicare, and MPRO.
9. RBRVS:	MSMS will serve as convenor for discussions with the 34 recognized Michigan specialty societies, to discuss the Harvard Resource-Based Relative Value Scale (RBRVS). MSMS also will propose four informational forums with RBRVS experts.
0. Physician Recovery Network:	MSMS is seeking legislation which would create a joint MSMS/Board of Medicine program to divert physicians into treatment and grant them immunity while working in the program. MSMS is actively pursuing alternative funding for the Network sponsored by MSMS and MAOPS.
1. Elder Care:	MSMS will establish liaison with the Michigan Office of Services to the Aging and the Michigan Chapter, AARP.
2. Media & Public Relations:	MSMS will increase efforts to serve as a reliable source of information to the public and media.
3. Non-dues Income:	MSMS will continue to improve its financial soundness by enhancing non-dues income. Hagadorn, Inc., a joint venture with MPMLC, is expected to provide a longterm real estate investment to enhance revenues. Physician Service Group, Inc., and the Peer Review Organization of Michigan, wholly-owned subsidiaries of MSMS, continue to increase non-dues revenues.
4. As Always:	MSMS will continue to emphasize county society activities, member communications, recruitment, benefits and political activity. As always, the goal of all MSMS activities is to ensure the availability of, and access to, quality medical care for the people of Michigan.



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MEDICALLY UNNECESSARY

1 Name of Beneficiary From Health Insurance Card

(First) John

(Middle) M.

(Last)

☒ Male

☐ Female

2 Claim Number From Health Insurance Card

5 1 1 0 8 2 4

3 Patient's Mailing Address (City, State, Zip Code)

Check here if this is a new address → ☐

123 Main Street

(Street or P O Box — Include Apartment Number)

Indianapolis

(City)

IN

(State)

46260

(Zip)

4 Describe The Illness or Injury for Which Patient Received Treatment

been extremely tired

DIAGNOSIS.

Just months ago, physicians' rights to due process were jeopardized when Medicare carriers issued thousands of refund notices for "medically unnecessary" services. Refund notices were being sent to patients and physicians without adequate claims investigation and without information to wage an appeal. Left unchecked, this process threatens to severely undermine the basic trust between physician and patient.

Things are different now. . .thanks to the AMA. Our committed work with the Health Care Financing Administration (HCFA) to solve this problem has paid off. Because of the AMA's determination to protect the rights of physicians and patients, HCFA has issued new instructions to Medicare carriers. Carriers are now required to contact physicians directly for additional information before any claim is denied or any patient notices are released.

But there's more work to be done. During the next few months, HCFA, working with the AMA, will develop an educational program for improving physician understanding of the whole process. We must continue to look out for your patients and for your rights, too. But we can't do it without your help.

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BCBSM
is seeking physician input, recommendations regarding new policies

By Susan H. Adelman, MD

This year, Blue Cross Blue Shield of Michigan (BCBSM) has requested physician input as it phases in the recommendations made by Lewin/ICF, the Washington consultants hired to help BCBSM improve their operations. In fact, one of the Lewin recommendations was that BCBSM seek more physician input than it did in the past.

Physicians are being asked by Blue Cross Blue Shield of Michigan to provide input and give recommendations, but MSMS members should understand that BCBSM programs are developed internally and still will happen whatever we say.

We only can soften impact and clarify language when new policies come out, but we cannot actually stop them. The physician contract is the next new program now that the Retrospective Profiling program has been developed. In this process, we have had the opportunity to review material developed by the BCBSM legal department and to provide assistance in clarifying their language. We are precluded by the Federal Trade Commission from negotiating any agreement regarding fees, but we can provide information and express our views concerning any issue, including reimbursement. We can make it clear that there are areas toward which physicians may be expected to react negatively and suggest changes in the language that would be more palatable to physicians.

If we have no involvement at all in such matters as the contract, it will simply be presented to physicians as written by BCBSM.

Not all of our suggestions will be incorporated into the final document, but those that are will greatly assist the physicians who sign new participation agreements.

Physicians need to understand that MSMS will not violate the Sherman Anti-Trust Act, nor exert the kind of leverage which would prevent a new contract from following the general lines desired by BCBSM.

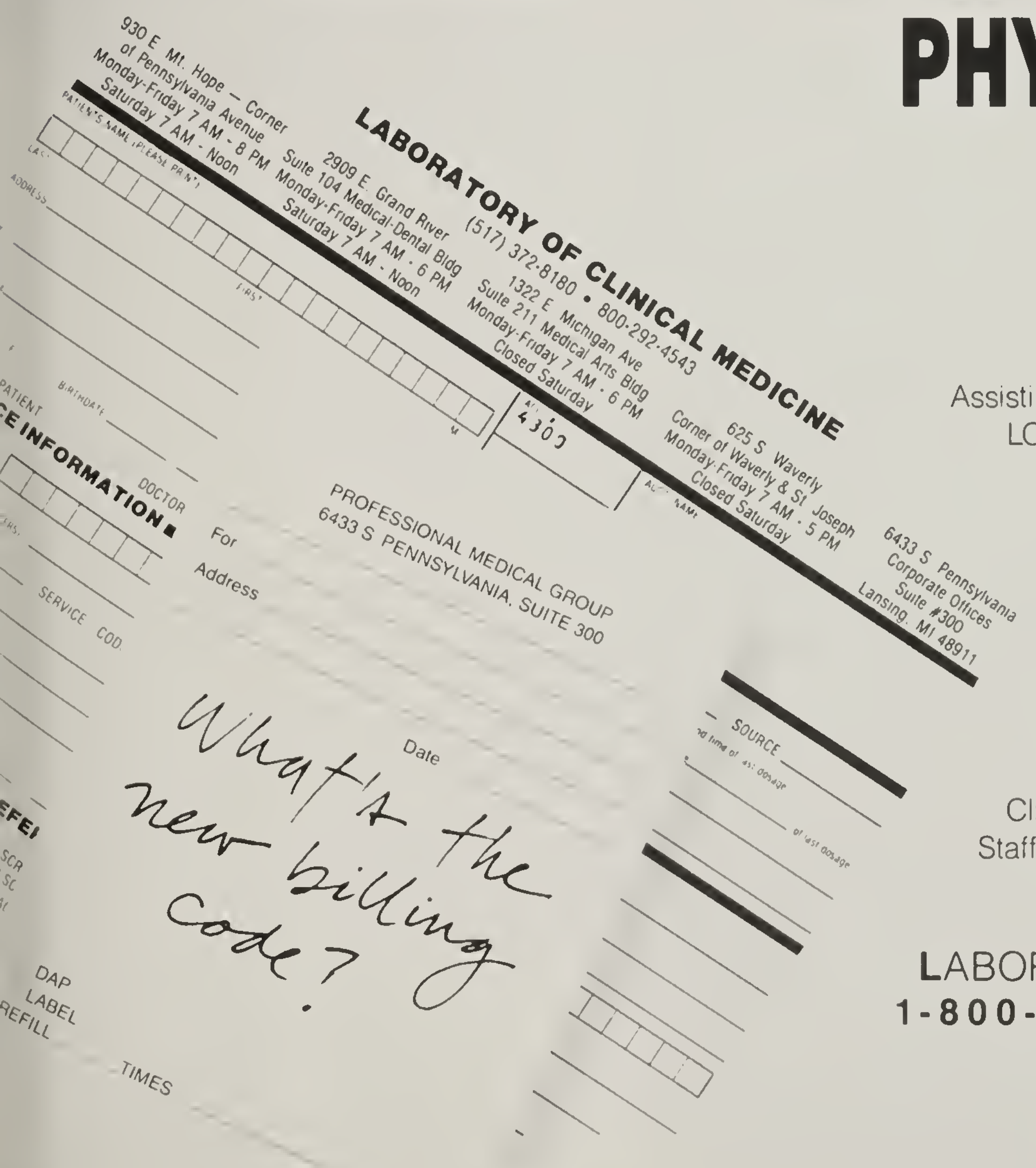
MSMS can help soften, ameliorate, recommend deletion and lessen the impact of a variety of clauses in the contract.

MSMS would like its members to know how much work goes into even accomplishing the possible. MSMS would like the support of its members in attempting the probable, and we ask our members to understand when we are unable to accomplish the impossible.

As soon as a draft of the contract is made available by BCBSM for wider physician commentary, MSMS will exert its efforts to focus a broad range of physician input into this process, and to identify those issues which its members feel still need to be addressed.

Doctor Adelman is MSMS president-elect and is chairman of the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan.

PHYSICIAN OFFICE LAB SERVICES



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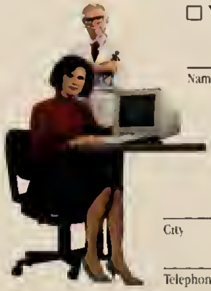

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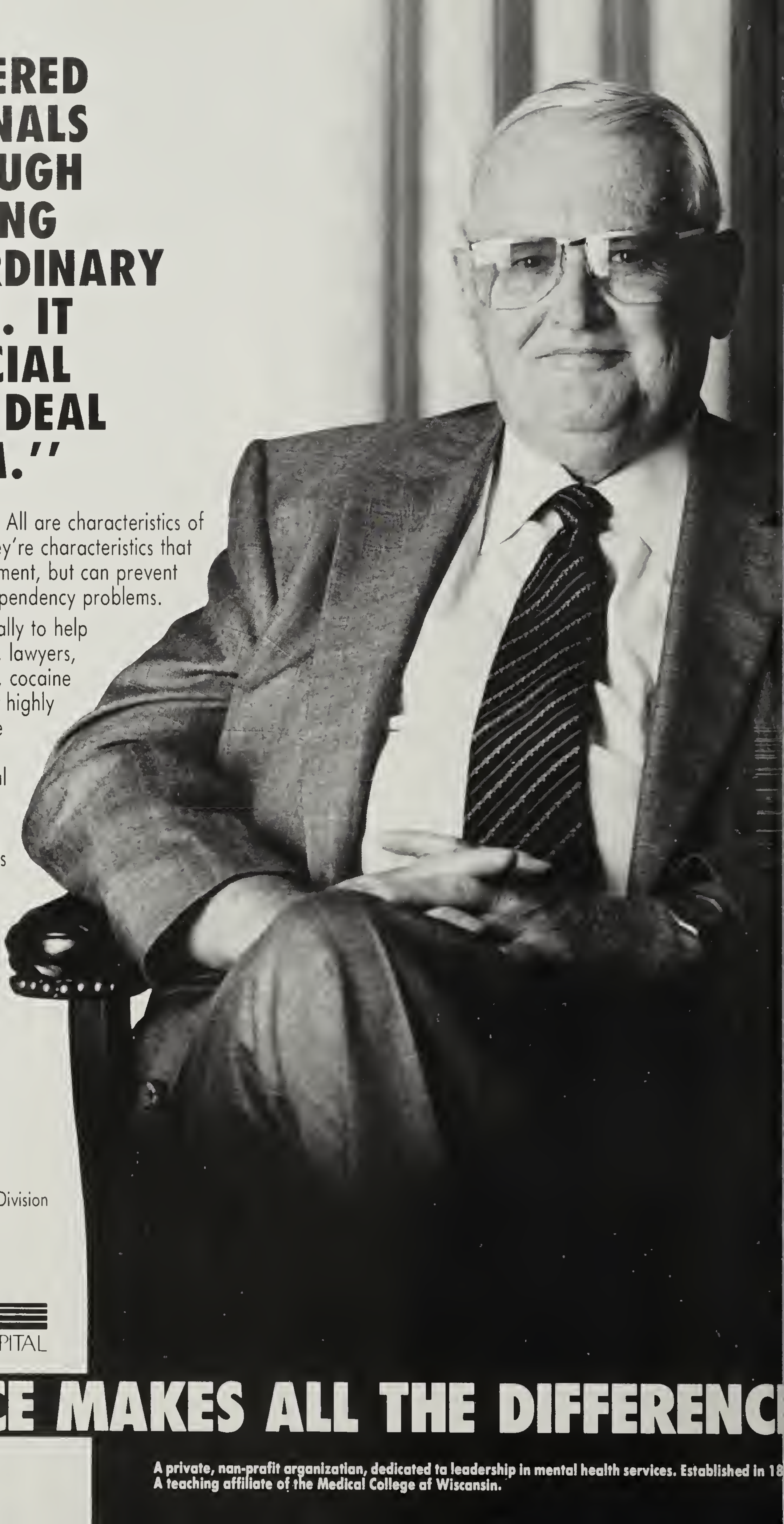

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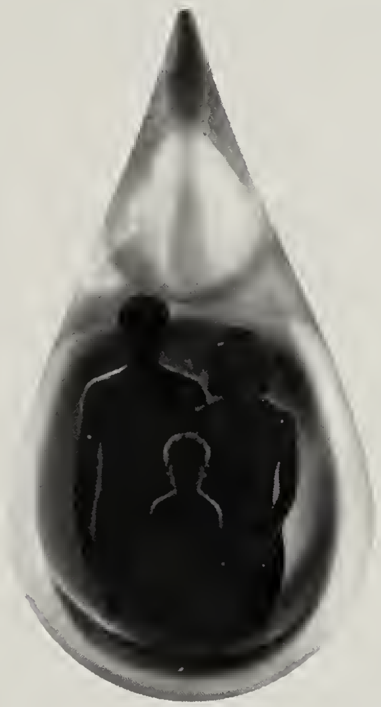

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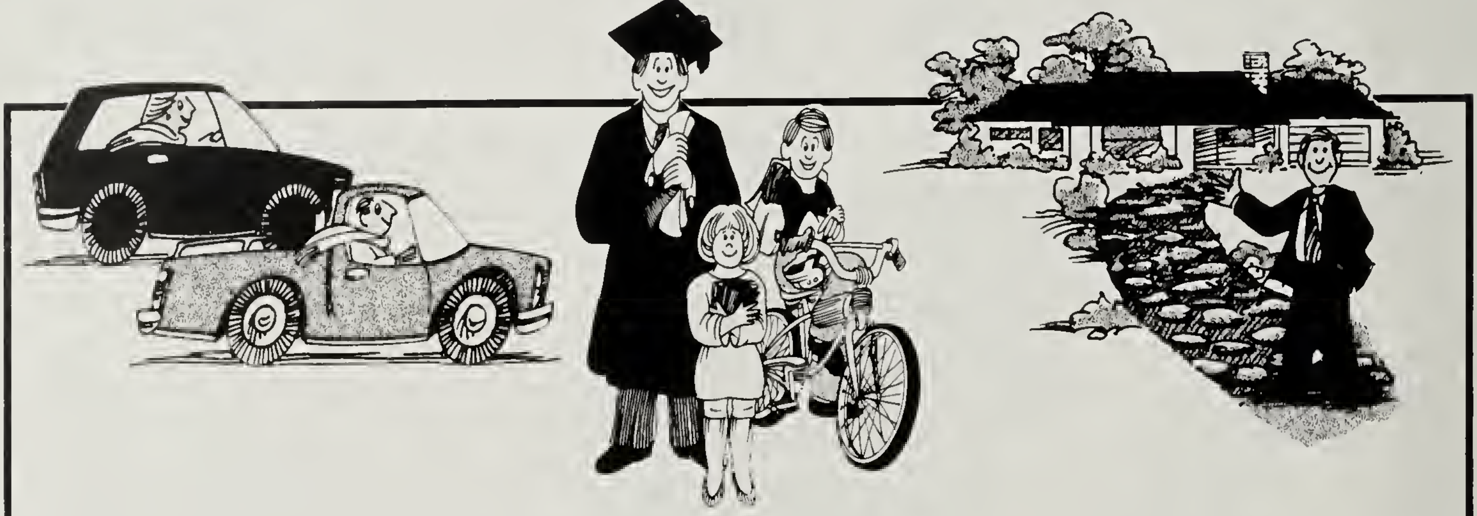

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Diagnostic Coding

It's here to stay!

By Jan Woerth

When Congress passed Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, the intent of the law was to protect Medicare beneficiaries from "catastrophic" hospital, doctor and prescription drug bills. What Congress perhaps did not realize was, that this law would prove to be a financial catastrophe for most medical offices. Public Law 100-360 requires that all medical diagnoses on Medicare claim forms be coded using the International Classification of Diseases, 9th Revision, Clinical Modification, better known as ICD-9-CM. While many medical offices were already using ICD-9-CM for diagnostic coding before the law was enacted (April 1989), very few of these offices were coding to the greatest level of specificity. In other words, the medical offices were not coding with the accuracy required by the law. This is the problem that will prove to be a catastrophe for many, if not most, medical offices.

Starting October 1, 1989, according to Blue Cross and Blue Shield (Medicare) of Michigan, all claim forms will be returned, unpaid if ICD-9-CM coding is not correctly completed. Medicare will request that codes be completed following the Conventions Used in the Tabular List (Volume 1 of ICD-9-CM) and that all diagnoses be coded to the greatest level of specificity. In addition, physicians not participating with Medicare (those not accepting assignment on all Medicare claims), will be fined if incorrect coding persists following notification of coding errors.

Does this sound confusing and/or a bit intimidating? If so, you are not alone in your feelings. Most people using ICD-9-CM do not know of or do not follow all of the conventions listed in Volume 1 of ICD-9-CM, nor do they always code to the greatest level of specificity. As a consequence, most people are coding incorrectly and their Medicare claim forms are simply not going to be paid. How can you prevent this from happening in your office? There are several steps that you can take to ensure that you and/or your staff are coding correctly.

Step One

First, participate in an ICD-9-CM coding course. Icd-9-CM was not designed to be a self-instructional coding system. Thus, it is nearly impossible to learn to code correctly without instruction. There is a great deal to learn about coding for you and your staff. As the physician, you are the only person allowed to diagnose in your office. Consequently, you will need to know what information to include in your diagnosis so that it can be coded to the greatest level of specificity. It may not be necessary for you to code if you have a responsible, well-trained staff that can code for you.

Step Two

Second, update your ICD-9-CM Volume 1 and 2 with the 1989 3rd Edition. New codes have been added to the 3rd Edition that are not found in the older editions. If your coding books are out-of-date, coding errors will be made. The 3rd Edition is available at government bookstores or by writing to the Government Printing Office, P. O. Box 360121, Pittsburgh, PA 15250-6121. The cost for the two volume set is $43.00. There are several private companies that also print ICD-9-CM books. Generally, these have helpful coding information not found in the government printed ICD-9-CM books but also cost more than the government books. Two of these companies are: CPHA, P. O. Box 971, Ann Arbor, MI 48106 and St. Anthony's Hospital Publications, P. O. Box 14212, Washington, DC 20044.

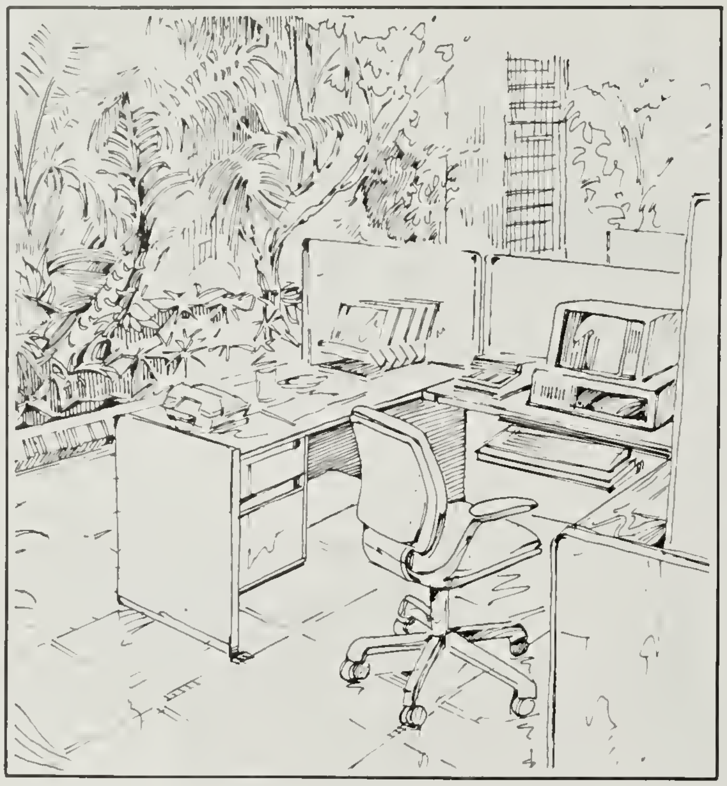
Step Three

Third, if your staff relies on a superbill, encounter form or computer for their ICD-9-CM codes, be sure that all codes are correct to the greatest level of specificity. An example of coding to the greatest level of specificity is demonstrated using diabetes mellitus, category 250. In order for this code to be correct, there must be a 4th digit that indicates the patient's diabetic complication (ketoacidosis, renal manifestations, peripheral circulatory disorders, etc.) and a 5th digit that indicates whether or not the patient is insulin dependent. Without this information provided by the 4th and 5th digit, the code is incomplete and thus, will not be paid by Medicare.

Step Four

Finally, allow your staff to set aside a specific time each day to code. Ideally, this will be a time solely devoted to coding so that costly errors will not be made. Remember, if coding errors are made, at the very least, claim forms will have to be recoded and resubmitted for payment. This requires extra staff time and slows down the payment process. If you follow these four steps ICD-9-CM will not be a catastrophe for your office, and you may find that your reimbursement from Medicare has actually improved. ■

Jan Woerth, a staff associate with Conomikes Associates, Los Angeles, California, submitted this article at the request of Physician Service Group Inc., an MSMS subsidiary.



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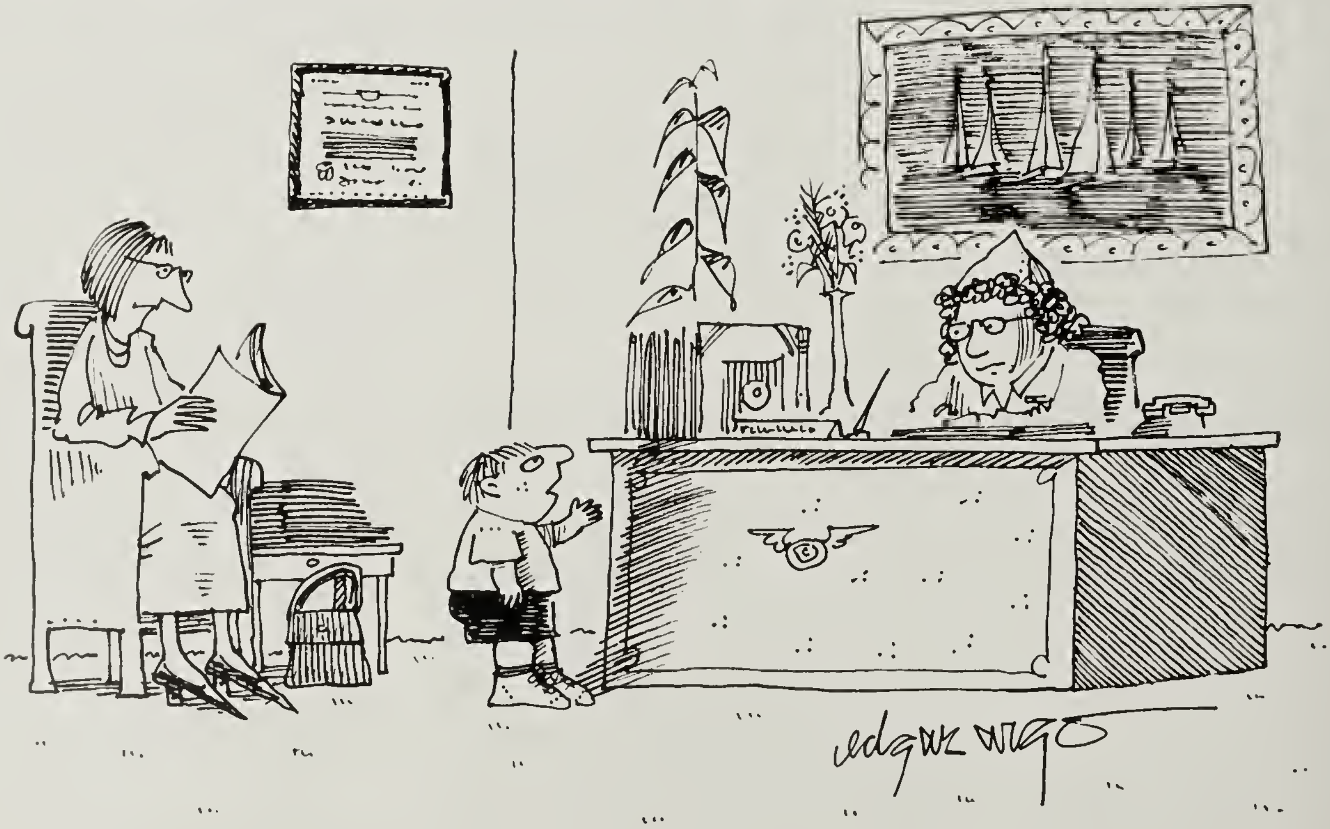

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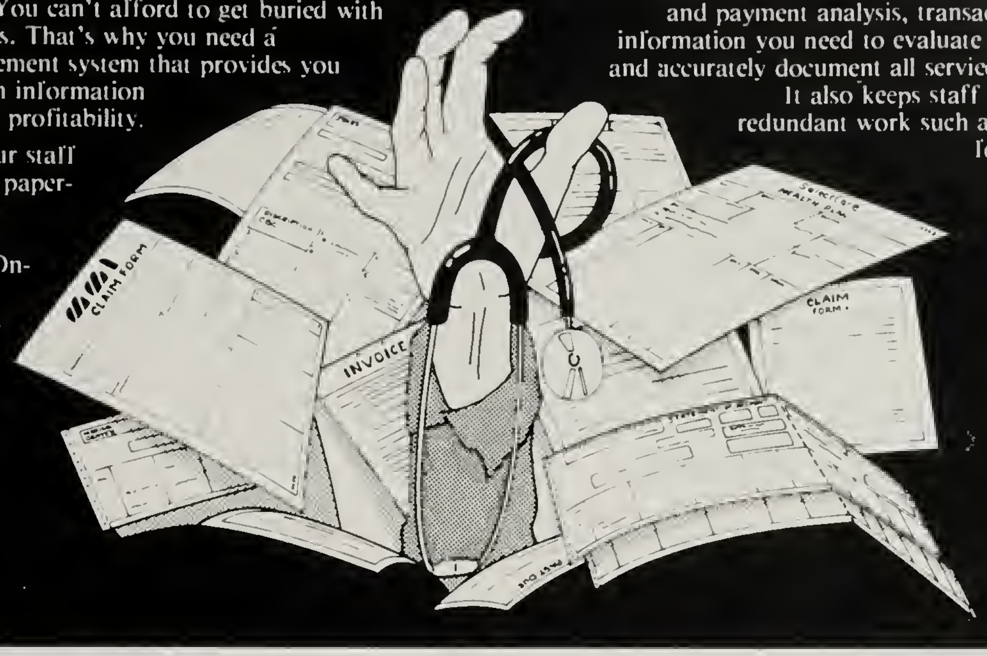

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DEATHS

Leland F. Carter, MD
Detroit

Leland F. Carter, MD, a Detroit ophthalmologist, died of leukemia August 30. He was 89. Doctor Carter attended the University of Pennsylvania Medical School and received his post doctorate training at Harvard University. In 1974, he retired after 30 years from a private practice he had with his brother, John Carter, MD. However, he remained on staff at the Detroit Receiving Hospital, Harper Hospital, and the Kresge Eye Institute. Doctor Carter was a member of the Wayne County Medical Society, the Michigan State Medical Society, the American Medical Association, the American College of Surgeons, American Academy of Ophthalmology and Otolaryngology, the Michigan Ophthalmological Society, and the Detroit Ophthalmology Society.

John D. Hamilton, MD
Adrian

John D. Hamilton, MD, an emergency room physician, died September 9. He was 67. After graduating from Wayne State University in 1946, Doctor Hamilton joined in practice with William Jewett, MD. From 1953 to 1955 he served in the US Army Medical Corps. When he returned to Adrian, he continued in private practice until 1978 and then decided to go into emergency medicine. Doctor Hamilton was on staff at Bixby Medical Center and held such positions as director of the emergency room, medical director of Hillhaven Convalescent Center, and medical consultant to the Medical Vocational Rehabilitation Center. He also was the medical examiner for Lenawee County. Doctor Hamilton was a member of the American Academy of Family Practitioners, Phi Beta Pi Medical Fraternity, the Michigan State Medical Society, the American Medical Association, and the American Academy of Emergency Room Physicians.

Roy D. Jones, MD
Birmingham

Roy D. Jones, MD, obstetrician and gynecologist, died September 10. He was 92. Doctor Jones received his medical degree from Wayne State University and then went on to serve on the medical staff at Highland Park General. He was the chief of obstetrics and gynecology when he retired in 1969. Doctor Jones was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association.

Francis V. Kowals, MD
Saginaw

Francis V. Kowals, MD, occupational medicine specialist, died September 9. He was 87. Doctor Kowals attended the University of Notre Dame and the University of Chicago - Rush Medical School where he graduated in 1927. He joined GM in 1931 as medical director of Chevrolet's small parts plant in Bay City. He treated the workers of GM for 36 years. A native of Poland, Doctor Kowals spent the last 48 years in the Saginaw area. He was a member of the American Medical Association, Michigan State Medical Society, and Saginaw Medical Association.

Claude M. Lowry, MD
Ann Arbor

Claude M. Lowry, MD, neurologist, died on August 31. He was 66. Doctor Lowry was a graduate of the University of Michigan Medical School and trained in neurology at the University of Michigan Hospital. He was on staff at St. Joseph Mercy Hospital from 1957 until his retirement in 1988. Doctor Lowry served in the US Navy during World War II and the US Air Force during the Korean conflict.

Frederick J. Melges, MD
Battle Creek

Frederick J. Melges, MD, retired obstetrician/gynecologist, died June 26. He was 87. Doctor Melges received his medical degree from Northwestern University and served his residency at Chicago Lying-In Hospital. He worked as an OB/GYN in Battle Creek from 1930-1979, then he retired. Doctor Melges was past president of the Calhoun County Medical Society and had served as chief of staff at Community Hospital. In 1970, he won a George Award in recognition of his contributions to the community. Doctor Melges also was a renowned inventor. He served as president of Walman Products, Chicago, and consulting vice president of American Hospital Supply Company, Evanston, IL, companies which manufactured many of his inventions. One of his most significant inventions was the disposable surgical drapery and gown. He was a member of American College of Surgeons, College of Gynecological Surgeons, Phi Rho Chi Medical Fraternity, Calhoun County Medical Society, Michigan State Medical Society, and the American Medical Association.

John D. Pool, MD
Grand Rapids

John D. Pool, MD, endocrinologist, died September 7. He was 66. Doctor Pool graduated from Calvin College and Wayne State University School of Medicine. He practiced medicine in Grand Rapids and Kalamazoo until he retired in 1986 due to a chronic illness.

Paul S. Sloan, MD
Houghton

Paul S. Sloan, MD, general surgeon, died March 8 at Portage View Hospital following a brief illness. He was 79. Doctor Sloan graduated from the University of Michigan Medical School and moved to Houghton in 1937 to join the Copper Range Medical staff. He served as chief surgeon for the Isle Royal Mining Co.; dean of staff and professor for the former St. Joseph's Hospital; president of the Houghton-Barage-Keweenaw Medical Society; and delegate to the executive council of the Michigan State Medical Society.

James W. Townsend, MD
Vandercook Lake

James W. Townsend, MD, general practitioner, died August 22. He was 94. Doctor Townsend served as chief of staff at Foote Memorial Hospital, Jackson for one year. He was a member of the Academy of General Practice, the Jackson County Medical Society, the Michigan State Medical Society, and the American Medical Association.

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How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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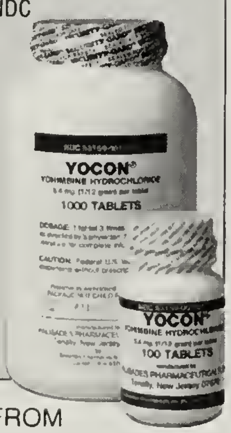

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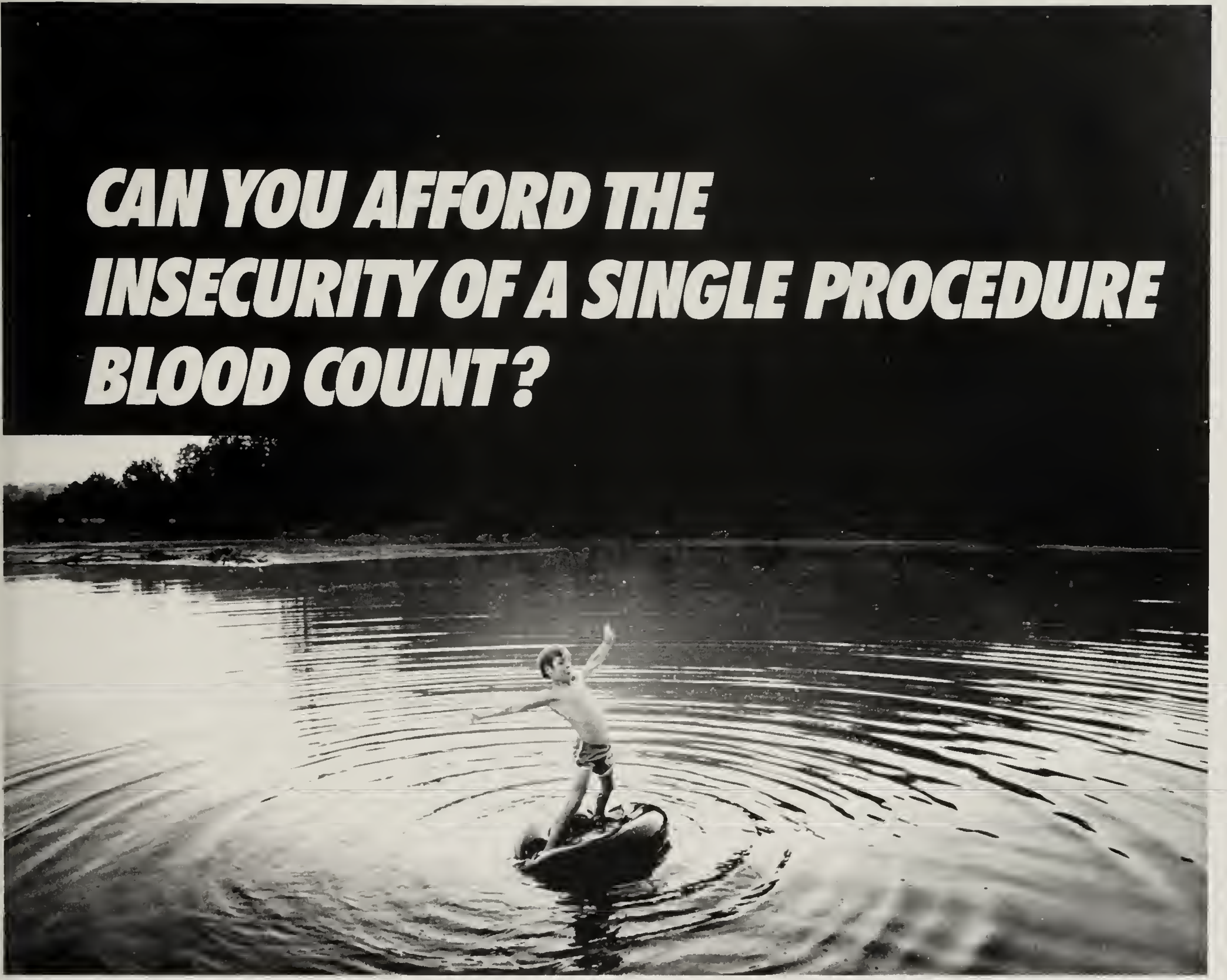
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Dorit D. Adler, MD — DR
3835 Windemere Drive
Ann Arbor 48105

Mark M. Bajorek, MD — FP
775 South Main
Chelsea 48118

James R. Black, MD — PD
80 First Street
Saurium 49913

William F. Crowley, MD — GS
44 S. Broad Street
Hillsdale 49242

Angela D. Desantis, MD — IM
1224 Walnut
Dearborn 48124

Carla'nne Dukes, DO — EM
7331 Greeley Road
Utica 48087

Gregory H. Hessler, MD — FP
2013 W. Marquette Woods
Stevensville 49127

Joseph A. Houle, MD — PTH
Alpena General Hospital
Alpena 49707

Stephen R. Knazik, DO — EM
7331 Greeley Road
Utica 48087

Michael J. Lucas, MD — GS
44199 DeQuindre #123
Troy 48098

Michael E. Mayle, DO — GP
6572 Red Arrow Highway
Coloma 49038

John M. O'Brien, MD — OBG
540 Horger Avenue
Dearborn 48126

Thomas K. O'Brien, MD — IM
515 S. Main Street
Chelsea 48118

Kianoosh Radsan, MD — OBG
16407 Southfield
Allen Park

John E. Raftery, MD — CD
207 Beaumont Place #6
Traverse City 49684

Russell B. Rothrock, MD — NS
302 Kensington #251
Flint 48502

Narciso D. Santiago, MD — FP
4200 Fashion Sq. Blvd.
Saginaw 48603

Joan K. Sharda, MD — NPM/PD
252 E. Lovell
Kalamazoo 49007

Mark F. Stegman, MD — OBG
847 N. Center Street
Gaylord 49735

John G. Waite, DO — GP
1210 N. Maple Road
Ann Arbor 48103

David H. W. Wohns, MD — IM/CD
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MEETINGS

MSMS Meetings

November

7-9, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn. Contact: Sherry L. Fent, Chief of Physician Education. (517) 337-1351 Ext. 28.

14-16, MSMS/PSG Medicare Series. Dearborn Inn, Dearborn (14th); Holiday Inn, East Lansing (15th); Amway Grand, Grand Rapids (16th). Contact: Amy C. Fistler, PSG Assistant to General Manager. (517) 337-1351. Ext. 65.

Michigan Specialty Society Meetings

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633.

National Specialty Society Meetings

November

11-15, American College of Allergy and Immunology, Orlando, FL, Contact: American College of Allergy and Immunology, 800 E. Northwest Highway #1080, Palatine, IL 60067. (312) 359-2800.

13-16, American Heart Association, New Orleans, LA, Contact: American Heart Association, 7320 Greenville Avenue, Dallas, TX 75231. (214) 706-1483.

16-18, American Society of Abdominal Surgeons. National Study Center, Tampa, FL, Contact: American Society of Abdominal Surgeons, 663 Main St., Melrose, MA 02176. (617) 665-6100.

26-12/1, 75th Scientific Assembly and Annual Meeting of the Radiological Society of North America, Contact: Carolyn Mills, Assistant Account Executive, 35 East Wacker Drive, Chicago, IL 60601. (312) 558-1770.

December

2-5, American Society of Hematology, Atlanta, GA, Contact: American Society of Hematology, 6900 Grove Road, Thorofare, NJ 08086. (609) 845-0003.

2-7, American Academy of Dermatology Annual Meeting, San Francisco, CA, Contact: American Academy of Dermatology, 1567 Maple Avenue, P. O. Box 3116, Evanston, IL 60204-3116. (312) 869-3954.

Other Meetings

November

8, Michigan Board of Vocational Experts, Fourth Bi-Annual Conference. Contact: Dr. John Caknipe, (313) 326-4280, or Ann Tremblay.

February

2-4, MSMA Mid-Winter Seminar: Roaring into the 90s. Contact: Yvonne Jones, CMA, 2864 Foster, Ann Arbor, MI 48104.

A WORD TO THE WHYS

WHY AMA? The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

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To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

November

9-10, Pediatric Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313)763-1400. **Approved for:** 17 hours Category I Credit.

10-11, 37th Annual Detroit Trauma Symposium. Location: Harper Hospital, Detroit. **Sponsor:** Harper Hospital. **Contact:** Marjorie Norum, Dept. of Surgery, Harper Hospital, 3990 John R, Detroit, MI 48201. (313) 745-2345.

11, Fifteenth Annual Symposium, How Psychoanalytic Therapy Works: A Contemporary Perspective. Location: Hyatt Regency, Fairlane Town Center, Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **Contact:** The Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633. **Approved for:** 6 hours Category I Credit.

13-14, 8th Annual Michigan Statewide Conference on Child Abuse and Neglect: Child Abuse and Substance Abuse. Location: Towsley Center, Ann Arbor. **Sponsors:** University of Michigan Medical School, University of Michigan Child Protection Team. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

17, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

17-18, Diabetes Mellitus Conference. Location: Fawcett Center for Tomorrow, Columbus, Ohio. **Sponsor:** Ohio State University Hospital. **Contact:** David Irwin, Associate Director, 921 Chatham Lane - Suite 101 Columbus, Ohio 43221-2476. (614) 459-3909. **Approved for:** 6.5 hours Category I Credit.

18-19, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

18, Every Doc's Pediatric Dermatology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Department of Dermatology. **Contact:** Diane Davis, Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202. (313) 876-3073 or (800) 888-4340. **Approved for:** 4.5 hours Category I Credit.

19-20, New Approaches to Patient Care in Diabetes: Psychosocial & Behavioral Issues. Location: Towsley Center, Ann Arbor. **Sponsors:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, Michigan Affiliate — American Diabetes Association. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

29, Michigan Physicians' Conference On Elder Abuse. Location: Grace Hospital, Detroit. **Sponsor:** St. Lawrence Hospital. **Contact:** Mick Goldynia, Geriatric Assessment Center, St. Lawrence Hospital, 1210 W. Saginaw, Lansing, MI 48915. (517) 337-0330. **Approved for:** 6 hours Category I Credit.

29-30, Second Annual Symposium on the Difficult Airway. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

30/12-1, AIDS Education Program. Location: Wayne State University Campus, Detroit. **Sponsor:** College of Nursing and Department of Psychology and School of Medicine. **Contact:** (313)577-5731.

December

4-6, Emergency Medicine: Orthopedics. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 18 hours Category I Credit.

8, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

8-9, Nutrition for Clinical Practice and Everyday Living Conference. Location: Hyatt on Capitol Square, Columbus, Ohio. **Sponsor:** Ohio State University Center for Continuing Medical Education. **Contact:** The Ohio State University Center for Continuing Medical Education, (614) 292-4985. Toll free (800) 492-4445. **Approved for:** 10.5 hours Category I Credit.

9, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

15-17, Pediatric Update. Location: Williamsburg, Virginia. **Sponsor:** American Academy of Pediatrics. **Contact:** CME Registration, Department of Education, American Academy of Pediatrics, P. O. Box 927, Elk Grove Village, IL 60009-0927. Toll-free 800-433-9016 ext. 7657. **Approved for:** 16 hours Category I Credit.

American Medical Association
Hospital Medical Staff Section
Fourteenth Assembly Meeting
November 30 - December 4, 1989

Medical Staffs from across the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly meeting November 30 - December 4, 1989 at the Sheraton Waikiki Hotel in Honolulu.

The HMSS Assembly provides medical staffs with a unique opportunity to discuss and participate in the policymaking process of the AMA. In addition to the Assembly Meeting, the HMSS will sponsor an educational program on a topic of interest to medical staffs.

For further information about the AMA-HMSS, please call (312) 645-4754 or 645-4761.

Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

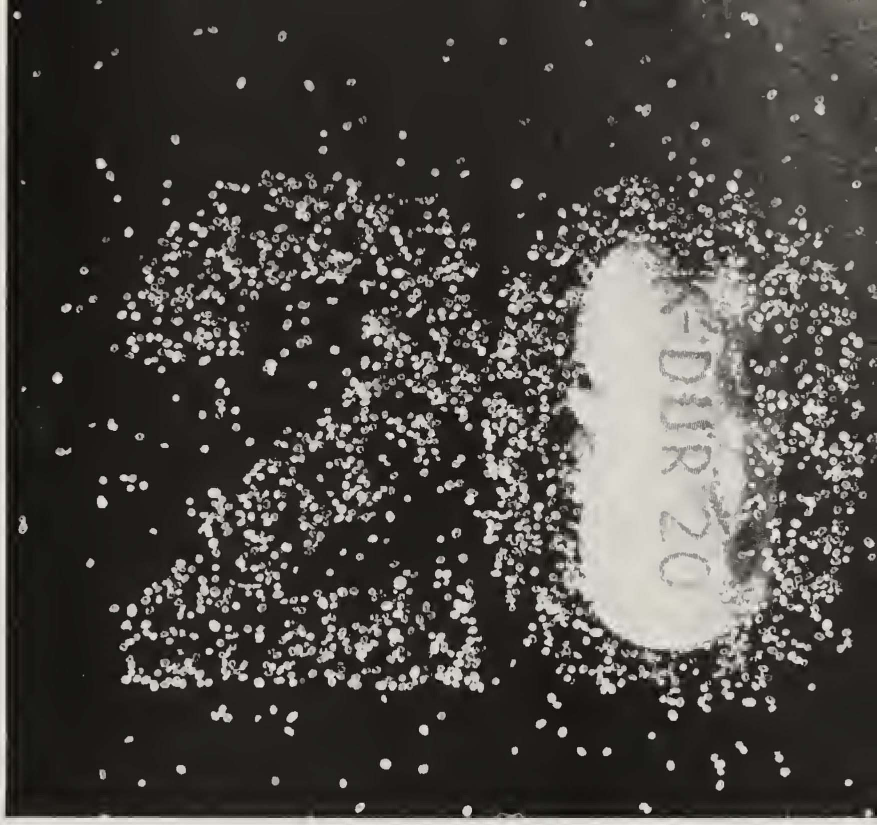
Name: Leon E. Butler, Jr., MD
Action, Date Taken: Revoked, July 3, 1989
Reason: Drug Related

Name: Raul E. Aranda, MD
Action, Date Taken: Revoked, Fined $5,000, August 18, 1989
Reason: Substance Abuse

Name: Saleem Azad, MD
Action, Date Taken: Suspended 6 months & 1 day, September 11, 1989
Reason: Conviction - Insurance Fraud

Name: Rameshbhai F. Patel, MD
Action, Date Taken: Revoked, Fined $20,000, August 10, 1989
Reason: Negligency - Incompetency

Name: David W. McKinney, III, MD
Action, Date Taken: Revoked, Fined $50,000, September 11, 1989
Reason: Conviction - Drug Related



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1. For the treatment of patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis. If hypokalemia is the result of diuretic therapy, consideration should be given to the use of a lower dose of diuretic, which may be sufficient without leading to hypokalemia
2. For the prevention of hypokalemia in patients who would be at particular risk if hypokalemia were to develop, e.g., digitalized patients or patients with significant cardiac arrhythmias.

The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern and when low doses of the diuretic are used. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases, and if dose adjustment of the diuretic is ineffective or unwarranted, supplementation with potassium salts may be indicated.

CONTRAINDICATIONS Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene, amiloride) (see **OVERDOSAGE**).

Controlled release formulations of potassium chloride have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium. Potassium supplementation, when indicated in such patients, should be given as a liquid preparation or as an aqueous (water) suspension of K-DUR (see **PRECAUTIONS**; **Information for Patients**, and **DOSAGE AND ADMINISTRATION** sections).

All solid dosage forms of potassium chloride are contraindicated in any patient in whom there is structural, pathological (e.g., diabetic gastroparesis) or pharmacologic (use of anticholinergic agents or other agents with anticholinergic properties at sufficient doses to exert anticholinergic effects) cause for arrest or delay in tablet passage through the gastrointestinal tract.

WARNINGS Hyperkalemia (see **OVERDOSAGE**)—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone, triamterene or amiloride) since the simultaneous administration of these agents can produce severe hyperkalemia.

Interaction with Angiotensin Converting Enzyme Inhibitors—Angiotensin converting enzyme (ACE) inhibitors (e.g., captopril, enalapril) will produce some potassium retention by inhibiting aldosterone production. Potassium supplements should be given to patients receiving ACE inhibitors only with close monitoring.

Gastrointestinal Lesions—Solid oral dosage forms of potassium chloride can produce ulcerative and/or stenotic lesions of the gastrointestinal tract. Based on spontaneous adverse reaction reports, enteric coated preparations of potassium chloride are associated with an increased frequency of small bowel lesions (40-50 per 100,000 patient years) compared to sustained release wax matrix formulations (less than one per 100,000 patient years). Because of the lack of extensive marketing experience with microencapsulated products, a comparison between such products and wax matrix or enteric coated products is not available. K-DUR is a tablet formulated to provide a controlled rate of release of microencapsulated potassium chloride and thus to minimize the possibility of a high local concentration of potassium near the gastrointestinal wall.

Prospective trials have been conducted in normal human volunteers in which the upper gastrointestinal tract was evaluated by endoscopic inspection before and after one week of solid oral potassium chloride therapy. The ability of this model to predict events occurring in usual clinical practice is unknown. Trials which approximated usual clinical practice did not reveal any clear differences between the wax matrix and microencapsulated dosage forms. In contrast, there was a higher incidence of gastric and duodenal lesions in subjects receiving a high dose of a wax matrix controlled release formulation under conditions which did not resemble usual or recommended clinical practice (i.e., 96 mEq per day in divided doses of potassium chloride administered to fasted patients, in the presence of an anticholinergic drug to delay gastric emptying). The upper gastrointestinal lesions observed by endoscopy were asymptomatic and were not accompanied by evidence of bleeding (Hemoccult testing). The relevance of these findings to the usual conditions (i.e., non-fasting, no anticholinergic agent, smaller doses) under which controlled release potassium chloride products are used is uncertain; epidemiologic studies have not identified an elevated risk, compared to microencapsulated products, for upper gastrointestinal lesions in patients receiving wax matrix formulations. K-DUR should be discontinued immediately and the possibility of ulceration, obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS General: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: When blood is drawn for analysis of plasma potassium it is important to recognize that artifactual elevations can occur after improper venipuncture technique or as a result of in-vitro hemolysis of the sample.

Drug Interactions: Potassium-sparing diuretics, angiotensin converting enzyme inhibitors (see **WARNINGS**).

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity and fertility studies in animals have not been performed. Potassium is a normal dietary constituent.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is unlikely that potassium supplementation that does not lead to hyperkalemia would have an adverse effect on the fetus or would affect reproductive capacity.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**).

The most common adverse reactions to oral potassium salts are nausea, vomiting, flatulence, abdominal pain/discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by diluting the preparation further, taking the dose with meals or reducing the amount taken at one time.

OVERDOSAGE The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of any agents with potassium-sparing properties.
2. Intravenous administration of 300 to 500 mL/hr of 10% dextrose solution containing 10–20 units of crystalline insulin per 1,000 mL.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

Caution Federal law prohibits dispensing without prescription.

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PRESIDENT'S PAGE

What can *you* do for MSMS?

By Robert E. Paxton, MD

The theme of this month's *Michigan Medicine* is membership. As president, it would seem appropriate for me to devote this page to the virtues of MSMS membership and the many member services available. I could elaborate on the fact that MSMS represents its members to the government, to the bureaucracies, to other health-related organizations and, of course, to the public through media exposure. I will do neither of these.

Though, indeed, I am tempted to take this approach, I will resist and instead paraphrase the question asked by President John F. Kennedy so many years ago: Ask not what your association can do for you, but what you can do for MSMS. This is not meant simply to be a rhetorical question but rather it is meant to get at the heart of what I have been talking and writing about since becoming your president — member involvement. Repetitious? Yes! But the concept of member involvement is so important that to repeat it is justified.

Give of yourself

What can you do for MSMS? The first thing you can do is to give of yourself. I was troubled when I read in a new regional specialty newsletter an implication that the Michigan State Medical Society was run by a select few and there was little that its individual members could contribute or control. If this is the perception of our members, we have a problem because just the opposite is true. MSMS is dependent upon its members for direction and advice. An all out effort is underway to inform and involve grass roots physicians in planning and decision making.

Today's medical environment is rapidly changing. It is not enough to dedicate oneself to his or her practice. We also must be involved in organized medicine. Active participation in MSMS is important to ensure quality care for our patients and to maintain the integrity of our profession.

The "how to" is simple. Seek committee assignments and positions of leadership. Attend meetings and contribute your opinions and ideas. Give your leaders your moral support as well as your input. Make MSMS a priority in your professional life. This is what membership means.

Join the liability fight

What can you do for MSMS? Join in the crusade to solve the liability crisis. This can take several directions. When your leadership calls upon you to contact your legislators or your governor, respond enthusiastically with determination and persistence. Take the time to write or call. I cannot impress upon you enough the importance of grass roots participation in the political process.

Deliver quality care

Perhaps the most important thing you can do is deliver quality care. Stay sharp and on top of medical advances. Efficient and competent doctors are a major line of defense in this battle. Coupled with this concept is the need to preserve a strong doctor/patient relationship. Yes, I'm guilty of constantly harping on this subject. I do it because it is so important for successful medical care and yet at the same time it is threatened by so many pressures in today's society.

I hear of physicians who want to increase volume of care to make up for fee discounts, capitation schemes, risk sharing proposals and reduction in reimbursement levels. The danger lies in not spending adequate time with each patient. Never let the individual feel that you are rushed. Always convey the idea that his problem is the most important thing that you have to deal with on that particular day. I will always maintain that this attitude is indispensable if we as an association hope to achieve success in resolving the malpractice crisis.

Voice your concerns

What can you do for MSMS? If you disagree with policy or with the direction that MSMS is taking, relay those findings to the proper person. Contact your county delegates, your district MSMS Board representative or any section or specialty delegate that represents you. For that matter, never hesitate to directly contact an officer of your society. We will respond, believe me! Don't discredit your organization but instead offer constructive criticism.

Remain united

Finally, what can you do for MSMS? Assume constructive attitudes! Remain united! Reimbursement policies and economic factors continue to isolate us to our own specialty interest and threaten unity — unity that is so necessary for preservation of quality medical care. It has been said that unity makes strength, and since we must be strong, we must also be one.

Be proud of our profession and optimistic about the future. Hold on to the altruistic character of medicine. Membership in your state medical society should be a big plus for you. Last, and most important, show your loyalty to the profession and to your patients. The future for all physicians depends upon it. ■

Doctor Paxton is MSMS president.

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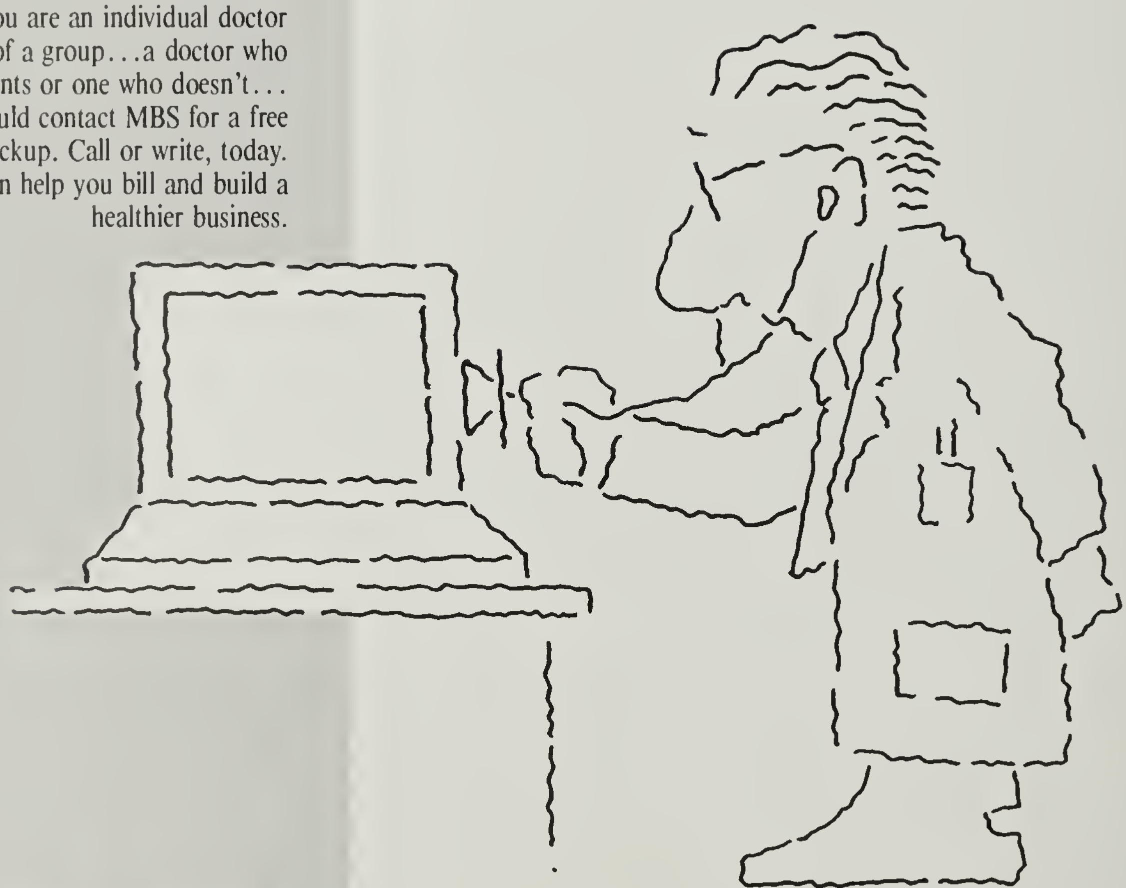

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MICHIGAN MEDICINE

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Continued discontent with the American approach to resolving medical malpractice problems has generated interest in alternative approaches and models. One such alternative is the system functioning in Sweden. Last August, an unlikely group of Michigan professionals travelled to Stockholm to take a first-hand look at the country's No-Fault Patient Insurance Fund. The unusual contingent from Michigan included physicians, lawyers, insurance representatives, legislators and other health care professionals. Despite the diversity of the group, all who participated in the trip agreed that the trip was, indeed, worthwhile. However, opinions varied greatly as to whether the Swedish system could actually work here in Michigan. The pros and cons of the Swedish system, as seen by many of those who travelled to Stockholm, is the subject of this month's cover story.

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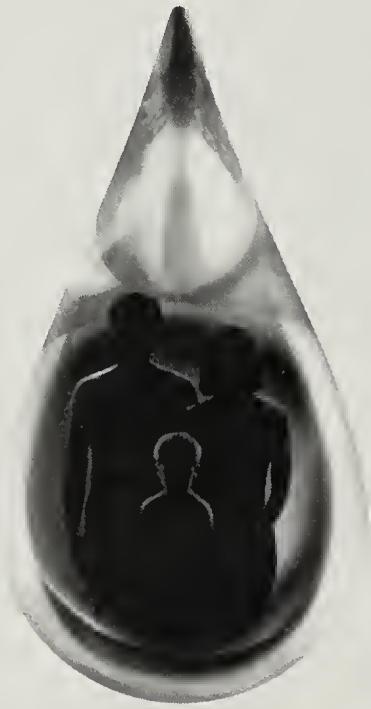

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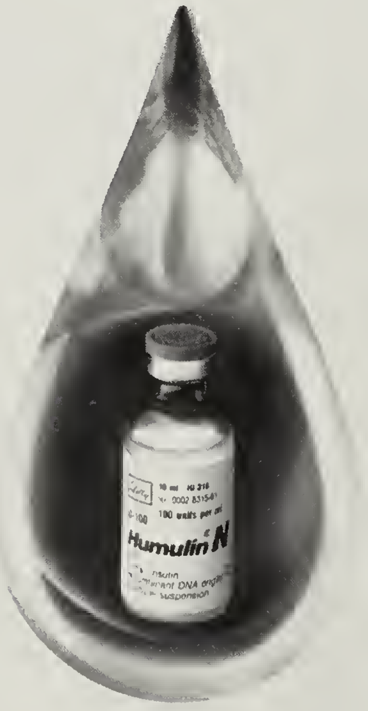

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The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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IN MY OPINION

Physicians Recovery Network Needs Your Financial Support

By James L. Fenton, MD

During my year as chairman of the MSMS Steering Committee on Program to Assist Impaired Physicians, one thing I've learned is that impairment doesn't discriminate. It can hit any of us in the form of alcoholism and/or chemical dependency, mental illness brought on by stress, physical disability due to an accident or stroke, or organic brain disorder. None of us are immune.

However, I've learned something else that I find remarkable and very reassuring: the dedicated physicians that volunteer their time to the Physicians Recovery Network are always there to help our colleagues. Over 250 physicians have been helped by the PRN, and new cases are being opened daily. PRN Medical Director Gerald A. VanderVoord, MD, tells us he is averaging six to eight calls a day regarding the program. In addition, he is making several presentations each month to county medical societies, hospitals, specialty organizations, and various paramedical groups.

All of this is being accomplished despite the financial woes we have been experiencing. As you know, the PRN has been going through some rough financial times. We thought we were all set a couple of years ago when Blue Cross Blue Shield of Michigan agreed to finance a major portion of the program. On the strength of that commitment, we hired our medical director and expanded our services. Then we suddenly lost that funding.

Last year I reported how the Physicians Insurance Company of Michigan (PICOM) and the Michigan Physicians Mutual Liability Company (MPMLC) came to our rescue with substantial grants to keep the program afloat, and I am pleased to let you know that these two fine organizations are continuing that support. Also, the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS) has doubled its contribution to the program.

But, that is not all. When I explained our dilemma to you, the individual MSMS member or hospital, many of you generously responded with contributions to the PRN by sending your checks to the Michigan Health Education Foundation. You made a difference and helped PRN keep going. I can't thank you enough for your generosity and support.

I wish I could tell you our financial problems have been solved now, but, unfortunately, that is not the case. We're exploring the possibility of getting a foundation grant, and the impaired physicians legislation we told you about last year (which would provide funding for the program) has been introduced by Representative David M. Gubow. These solutions look promising, but neither will solve our immediate need for funds.

So, once again, I am asking you for a helping hand in getting us over this crisis. Any contribution you feel you can make to this very worthy cause, large or small, will be greatly appreciated. Just send your tax-deductible check to the Health Education Foundation (noting it is to be earmarked for the Physicians Recovery Network), and address it to Box 950, East Lansing, MI 48826-0950. I personally can assure you it will be put to very good use.

In the meantime, we'll keep you advised through *Michigan Medicine* and *Medigram* on the status of Representative Gubow's impaired physicians legislation, what progress we are making in securing a foundation grant, and other funding mechanisms.

Thanks for your support. ■

Doctor Fenton is a member of the MSMS Board of Directors and the MSMS Committee on Publications, and serves as chairman of the MSMS Steering Committee on Program to Assist Impaired Physicians.

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How to Register

ACP Members will receive the Advance Program of convention information and registration by December 1, 1989.

Non-members, please look for the complete schedule of events and a registration form in our 12-page insert appearing in the December 1 issue of *Annals of Internal Medicine*. Non-members can also call 1-800-523-1546 (extension 2429). In Pennsylvania, call 215-351-2429.

Pre-registration deadline: March 19, 1990. MIMD

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Letters from Our Readers

MSMS president is commended for his "visionary" message

As a founding member of the Michigan Association of the Professions, an organization intended to preserve professionalism and represent the interest of all professions, I write to commend our president, Robert E. Paxton, MD, for his clarion-call as stated in the President's Page of our October 1989 issue of *Michigan Medicine*.

Doctor Paxton's message is visionary, sincere, mature, and responsible, which I feel deserves our attentive ears. His recognition that the time has come for cooperation for the common good and the reduction of an adversary relationship with others certainly rekindles the flame of Altruism, which I am sure most of us felt when we first decided to become physicians.

John L. Shek, MD
Michigan Association of the Professions
Saginaw, MI

Article on low-level radioactive waste is examined, criticized

I wish to comment on the article entitled, "Low Level Radioactive Waste," by Mary Sinclair, MS, which appeared in the August 1989 issue of *Michigan Medicine*. I was surprised that the Michigan State Medical Society would publish an article on this subject by an anti-nuclear activist when there are many physicians within MSMS who are more knowledgeable than Sinclair on the risks and benefits of siting a Low Level Radioactive Waste (LLRW) facility in Michigan.

Sinclair's article complains about the political process that led to the enactment of federal legislation mandating that all states must provide for safe disposal of LLRW generated within their borders by January 1, 1993. She recommends that Michigan withdraw from the Midwest Compact and that all wastes then be stored at reactor sites "until such time as Congress addresses the many issues that can be resolved only at the federal level." Such an action is ill-advised and would lead to immediate closure of the three currently available disposal sites to Michigan-generated LLRW. All generators of LLRW (hospitals, laboratories, medical research and industrial facilities, nuclear power plants, etc.) would then need to store their waste until a disposal facility is available in Michigan.

States operating LLRW disposal sites are not going to let other states such as Michigan gain the medical, energy, and manufacturing benefits afforded by nuclear technology without sharing the costs and well-defined *low risk* of waste disposal. Congress is not going to readdress this issue in the foreseeable future and reactor sites are not designed to store LLRW on a permanent basis.

At least 25 to 30 percent of LLRW by volume is medically related and has decreased considerably in volume as users have compacted and incinerated their LLRW that can be handled in this fashion. However, disposal facilities still are needed and a central, well-maintained site makes a lot more economical and safety-conscious sense than spreading the LLRW to many, uneconomical sites.

As originally promulgated, the Federal legislation envisioned four to seven sites nationwide, but additional sites have been added as states have shown their unwillingness to trust each other. Going it alone, such as Texas and New York decided to do, is economically unsound unless there is sufficient volume in-state to justify this approach (not present in Michigan).

Sinclair states that "there is no upfront money to pay for the facility." This is incorrect, for there is money deposited by LLRW users held in an escrow account that will be released to the Compact for site preparation *if* the Compact meets its performance deadlines. Further delay jeopardizes this funding.

Sinclair details the problems associated with previous disposal facilities that are not relevant to current technology. The three current disposal sites are well-maintained and safe. No health problems have been associated with their operation. The same cannot be said for other non-nuclear disposal sites.

Lastly, the United States has the best health care system in the world. Many of the latest technological advances in drug therapy and patient management would not have been made without access to nuclear technology. The "not in my backyard," philosophy espoused by Sinclair is no longer tenable. Failure to act responsibly by not creating a LLRW facility in accordance with legislated national policy will be detrimental to health care in Michigan.

John E. Freitas, MD, FACP
President, Central Chapter,
Society of Nuclear Medicine

Professionalism, not selfishness, should drive physicians

As Thomas R. Berglund, MD, stated in the "In My Opinion" column in the November issue of *Michigan Medicine*, MSMS membership is a privilege.

Several years ago, I wrote an article stating that membership is something all of us owe to the profession as a payback for what the profession has given us. But even more important is the issue that we should see ourselves as professionals, concerned about the whole, and lay aside our selfishness, whose main theme is, "What's in it for me?"

Unless physicians see the big picture of the importance of working together, we will be victims of our own apathy and selfishness as we are forced ever closer to increased bureaucratic control and socialized medicine. We need to think of the whole, which in the long run will best serve the individual. Until we adopt professionalism over individualism, altruism over materialism, our fate is clear.

Unfortunately, this (letter) is like preaching to the choir. Those who need this information the most (probably) are not reading it. Our only hope is that whose who are reading this (letter) will spread the message of professionalism.

Joseph Arends, MD
Troy

WHOM TO CALL AT MSMS HEADQUARTERS

EXECUTIVE DIRECTOR: WILLIAM E. MADIGAN
ASSISTANT DIRECTOR: KEVIN A. KELLY
(517) 337-1351

The individuals listed at right are a very integral part of the Michigan State Medical Society – they are the staff. The 55 members of the staff provide a wealth of information and assistance every day to MSMS members who have questions and want answers.

Here are just a few of the questions MSMS has received and answered: "Medicare has not sent a payment in three months and I have provided over $60,000 worth of treatment. Who can I talk to at BCBSM about this problem?" "I neglected to renew my license and I am scheduled for surgery tomorrow. I cannot reach the Department of Licensing and Regulation. Can you help me?" Staff was able to provide assistance to these physicians and stands ready to assist the membership everyday.

Do not forget that the MSMS staff members listed at right can help you through a bureaucratic maze, give you the most complete information about the current health care delivery system, or simply provide you with directions to the MSMS building. If you have questions, we encourage you to pick up the phone and call us.

Address changes	Peg Berry
Advertising (in *Michigan Medicine)*	Betty McNerney
AIDS Provider Education Project	Lisa Strother
AMA Delegation	Sherry Wellman
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Mary Anne Ford
Auto Lease Plan	Richard Campau
Blue Cross Blue Shield/Third Party Payors	Robert Ortwein
Board of Medicine	Dan Farhat, Tom Wolff
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (in *Michigan Medicine)*	Sherry Fent
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Federal Legislation	Kevin Kelly
Financial Operations	Richard Campau
Graduate Medical Education	Sherry Fent
Group Health Insurance Plan	Barb Zimmerman
Health Education Foundation	Vada Davis
HMOs/PPOs	Robert Ortwein
Hospital Medical Staff Relations	Tom Plasman
Judicial Commission	Katie Brewbaker
Legislation	Dan Farhat, Tom Wolff
Maternal Health Conference	Sherry Fent
Media Relations	David Fox
Medicaid	Mary Anne Ford
Medical Assistants	Caroline Kimmel
Medical Ethics	Katie Brewbaker
Medicare	Robert Ortwein, Rose Heald
Medigram	Judy Marr
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Membership Records	Peg Berry
Membership Recruitment	Deborah Zannoth
Michigan Allergy Society	Viola Heins
Michigan Association of Medical Education	Viola Heins
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medical Group Managers Association	Caroline Kimmel
Michigan Medicine (MSMS Journal)	Judy Marr, Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
Michigan Society of Internal Medicine	Caroline Kimmel
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Physicians Recovery Network	Katie Brewbaker
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Physician Legislative Network	Dan Farhat, Tom Wolff
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Professional Liability Insurance	Richard Campau
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MEDICAL NEWSFRONTS

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Athletes' use of steroids, alcohol is increasing, MSU study shows

A national survey shows that the use of performance-enhancing drugs such as anabolic steroids and "social" drugs such as alcohol by college athletes has increased slightly over the last four years.

The survey, conducted by two Michigan State University researchers, also shows that the use of other social drugs, such as marijuana and cocaine, has dropped. However, the use of smokeless tobacco has increased by nearly 40 percent.

William Anderson, MD, associate professor of medical education, and Douglas McKeag, MD, associate professor of family practice, replicated a study they did four years ago which surveyed college athletes on their drug-using habits.

"This is a classic good news-bad news situation," said Anderson. "The bad news is alcohol use remains high, the use of anabolic steroids is up slightly and the use of smokeless tobacco is up nearly 40 percent. The good news is that the use of drugs such as marijuana, cocaine, and crack is down."

According to their most recent survey of more than 2,000 student athletes, 89 percent of the athletes said they have used alcohol within the past 12 months. This compares to 88 percent in the 1985 study.

However, only five percent of the athletes said they have used cocaine or crack, down from 17 percent in the 1985 study. In addition, the use of marijuana and hashish dropped from 36 percent in 1985 to 28 percent.

The new study shows that five percent of the athletes said they have used anabolic steroids, which have been linked to health problems such as cardiovascular disease, impaired liver function and reproductive problems.

"An interesting point is the distribution of anabolic steroid use," said Doctor Anderson. "Four years ago, its use was pretty much restricted to only Division I schools. We have found that it's now equally used among Division II and III schools."

The researchers said they were alarmed by the dramatic increase in the use of smokeless tobacco products. They found that nearly 60 percent of college baseball players use smokeless tobacco, and nine percent of women softball players said they have used it.

"This just flies in the face of any and all efforts at education," said Doctor Anderson. "Over the last four years there's been a tremendous increase in the amount of drug education and there's been a ban on the advertising of smokeless tobacco. You would think that all these things would tend to decrease the use."

The study also found that the use of amphetamines is down slightly, while the use of major pain medications — prescribed drugs such as codeine — is up.

The study also showed that more student athletes now believe there is a drug problem in college athletics (72 percent said they felt there is a problem, compared to 60 percent five years ago). In addition, more than half of those surveyed felt drug testing should be mandatory.

The study, supported by a $30,000 grant from the National Collegiate Athletic Association, surveyed 2,282 student athletes from 11 colleges and universities. Surveyed were 1,552 men participating in football, baseball, basketball, track and field, and tennis, and 730 women participating in basketball, softball, track and field, swimming and diving, and tennis.

Six of the participating schools were from Division I, three from Division II, and two from Division III. Geographically, three schools were located in the East, two in the South, four in the Midwest and two in the West.

Expensive drugs put cost squeeze on hospitals, says U-M pharmacist

The availability of effective, but expensive, new drugs is putting hospitals in the middle of a financial tug of war, according to a University of Michigan pharmacist.

Physicians want to prescribe new genetically engineered drugs like tissue plasminogen activator (TPA) for heart attacks or AZT for Acquired Immune Deficiency Syndrome, says Richard F. de Leon, but most government medical reimbursement programs and many private insurance companies refuse to pay for them. That leaves hospitals holding the financial bag, and the burden can be very heavy.

"A single dose of TPA, which dissolved blood clots in heart attack patients, costs $2,200," says de Leon, director of pharmacy services at the U-M Hospital and association dean for clinical sciences in the College of Pharmacy.

"Sandostatin, a new drug for diarrhea caused by gastrointestinal tumors and other gastrointestinal problems, will cost the U-M Hospital pharmacy $500,000 in the first year alone, and one million dollars in the second year," de Leon says. "The hospital spends one million dollars per year to treat just 100 short-stature children with genetically engineered human growth hormone."

Pharmaceutical companies spend millions of dollars on research and testing to bring these new drugs to market, de Leon explains, and drug manufacturers pass those costs on to consumers. In many cases, a new drug is only available from one supplier. Even when several pharmaceutical firms produce the same drug, normal laws of competition do not seem to apply.

"Take Ceftazidime, for example," says de Leon. "Three different pharmaceutical firms produce this antibiotic, but no matter where we buy it, the price is always $11.08 per gram.

"I get the feeling the price for these new drugs is often what the market will bear plus an additional percentage point

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or two. It appears that the manufacturer is trying to get all of its investment back in the shortest possible time. In some respects it's understandable, because a competitive drug may be introduced, reducing the return on the original drug. However, this approach leads to incredible prices that must be borne by the provider and passed on to the consumer."

According to de Leon, the cost squeeze on hospital pharmacies will get worse. "We've only seen a portion of the iceberg when it comes to the number of high-tech drugs that will be introduced in the next few years," de Leon says. "Hospitals must be better prepared to cope with increasing pharmaceutical costs."

De Leon says hospital pharmacists should take action now to prepare for higher drug costs in the future. In a recent article published in the summer issue of Current Concepts, de Leon recommended hospitals adopt pharmaceutical cost-control programs like those currently in place at U-M Hospital.

De Leon says the first step toward pharmaceutical solvency is a strong, well-informed pharmacy and therapeutics committee — made up of pharmacists, physicians, and administrators — to determine which drugs will be placed on the formulary, a list of drugs authorized for used in the hospital.

De Leon says clinical pharmacists must become more involved in containing costs, monitoring drug therapy, establishing drug protocols and educating physicians about less expensive alternative therapies.

Beaumont Hospital seeks diabetics for research project

The William Beaumont Hospital Clinics of Preventive and Nutritional Medicine currently are seeking diabetic volunteers for a research project involving a new blood pressure medication and its effects on blood insulin and blood sugar levels.

The length of the research study is approximately six weeks including three overnight visits. The research volunteer will be paid $100 for each overnight stay. Candidates must be adult onset diabetics, male or female, between the ages of 35 to 65 years.

Interested candidates for this research study should call the Beaumont Clinics of Preventive and Nutritional Medicine at (313) 646-6500.

Wayne State medical students lecture on STDs

Over 100 students from Wayne State University School of Medicine are involved in a program to educate young people in the Detroit metropolitan area about sexually transmitted diseases, especially herpes and AIDS. The Wayne State STD/AIDS Program is funded by the Michigan Department of Public Health and was established with the belief that prevention through education is the key to fighting sexually transmitted diseases. The program, in its fourth year at Wayne State University, reached approximately 4,000 students last year.

The medical students have volunteered to present two-part lectures to interested groups ranging in age from pre-teen to adult. The first lecture in the series deals with the STDs and the second with AIDS. The student volunteers are taught the latest information concerning STDs and AIDS and also are trained in communicating this information to adolescents and young adults. The speakers use handouts and audiovisuals to cover topics such as reproductive anatomy, symptoms of specific STDs

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Physicians in the News

Donald H. Kuiper, MD, vice president for medical affairs, St. Lawrence Hospital, Lansing, and associate professor of medicine, Michigan State University College of Human Medicine, is a newly-appointed member of the National Board of Medical Examiners' Comprehensive Part II Committee. The Comprehensive Part II Committee consists of scientists and clinicians. The aim of the Committee is to encourage development of test specifications which are not bound by specific disciplines and are interdisciplinary in scope. Doctor Kuiper also serves as a representative member of the Federation of State Medical Boards on the National Board of Medical Examiners.

Bruce H. Drukker, MD, professor and chairman, Department of Obstetrics & Gynecology, Michigan State University College of Human Medicine, will travel to Melbourne, Australia, for a lecturing tour. He will be speaking before the Royal College of Obstetricians and Gynecologists, the University of Melbourne, and the faculty of the Mercy Maternal Hospital. Doctor Drukker will be participating in the OB/GYN clinical and oral examinations for the fifth year medical students.

Jose Goldman, MD, PhD, a diabetologist and director of Henry Ford Hospital's Endocrinology and Metabolism Research Laboratory, is president of the American Diabetes Association, Michigan Affiliate's Board of Directors, for his second consecutive year. Prior to his election to affiliate president, he acted as vice president and chairman of the Affiliate's Research Peer Review Committee. Doctor Goldman serves as a clinical associate professor of medicine at the University of Michigan Medical School in Ann Arbor.

The Michigan Society of Internal Medicine recently elected new officers for 1989-90. They are: **Jack M. Shartsis, MD,** Warren, president; **John R. Maurer, MD,** Grand Rapids, president-elect; **Vernon E. Wendt, MD,** Grand Rapids, secretary-treasurer; and **Joseph J. Weiss, MD,** Livonia, past president.

Sheikh M. Saeed, MD, division head of Hematopathology and medical director of Blood Banks, Henry Ford Hospital, is the new president of the Michigan Association of Blood Banks (MABB). The MABB is the association of hospital and community blood banks, transfusion services and immunohematologic services.

Continued from page 10

and methods of transmission and prevention. A question and answer session is included in both lectures. While giving practical information on the recognition, prevention, and treatment of sexually transmitted diseases, the program stresses that the safest way to avoid contracting a STD is by abstaining from sexual activity.

The program is free of charge and can be used as the State-mandated AIDS education or to supplement a broader sex education curriculum.

Anyone interested in more information about this program can call the office of Community Medicine, Wayne State University School of Medicine, (313) 577-1033.

Mind-body-spirit intervention can reverse coronary heart disease, researcher says

Can lifestyle changes alone, without drugs or bypass surgery, halt or reverse the hardening of arteries that can lead to a heart attack?

A 36-year-old assistant of clinical medicine at the University of California at San Francisco believes the answer to that question is "yes" and the research he has been conducting in cooperation with the John E. Fetzer Foundation and Institute, Kalamazoo, is starting to back up his hypothesis.

Dean Ornish, MD, president and director of the Preventive Medicine Research Institute in Sausalito, California, has presented his findings to the American Heart Association's (AHA) annual scientific sessions. His report attracted front-page coverage in *USA Today* and in the health sections of the *Washington Post* and the *New York Times*.

Doctor Ornish's project is described as the first controlled clinical research to determine if mind-body-spirit intervention can reverse coronary heart disease, the number one cause of death and disability in the United States and the industrialized world, without using cholesterol-lowering drugs or surgery.

The Ornish protocol focuses on changing the attitudes and belief systems of patients with serious blockage of the coronary arteries by helping them make lifestyle revisions. This is done by peer support and family reinforcement to alter lifelong unhealthy habits.

Among the modifications introduced to the targeted patients are improved diet and nutrition, stress-reduction strategies, aerobic exercises, yoga, meditation, positive visualization techniques, and a cessation of smoking. For example, patients visualize their hearts pumping more freely. They avoid caffeine and drastically decrease their consumption of red meat.

"Such research was once impossible because the tools needed to detect very small, subtle changes in blockages were not developed," said Doctor Victor Eichler, the Fetzer Foundation program associate who coordinated the link with the Ornish project. "The marriage of medical research and the computer changed all of that. Doctor Ornish's project dovetails nicely with the Fetzer Foundation's prime mission to support scientific research and education into mind-body-spirit relationships that can empower patients and can lead to low-cost, complementary health care."

Doctor Ornish's research team recruited 50 volunteers, all with blocked coronary arteries and some serious enough to warrant bypass surgery. Half followed the Ornish strict regimen — no smoking, moderate exercise, vegetarian meals with no animal fats, twice-a-week group discussions, an hour of meditation and yoga relaxation exercises each day. As a control group, the other 25 followed the advice of their personal physicians, which called for only a moderate, less intense change in lifestyle.

Doctor Ornish reported recently that in the first year, 10 of the 12 in the comprehensive treatment group improved in health. Their coronary disease not only halted, but started to reverse itself. The conditions of 11 of the first 17 in the control group deteriorated, as measured by the highly sophisticated measuring devices. According to Doctor Ornish, the comprehensive treatment group had the largest reduction in total cholesterol and harmful LDL cholesterol ever reported without the use of drugs.

"Most of the treatment-group patients have improved dramatically in their functional status," he said. "Most are virtually free of chest pain despite markedly increased work levels, even for those who were experiencing daily angina before entering the study."

Still to be determined in future Ornish research is which modifications are the most effective and if these improvements are long-term. There is evidence, though, that bypasses don't last, especially if the patient continues to do the things that produced the clogged arteries in the first place.

Although the Ornish findings are still preliminary in nature, health-care experts are saying that his work could reshape the nation's approach to the treatment of heart disease, could change the way Americans live and could add to the country's life expectancy.

Salty diet worse for obese teens than for slim, U-M study says

The link between sodium intake and high blood pressure is nothing new. However, the role of blood pressure and salt consumption among obese adolescents only recently has been documented.

According to a U-M study published recently by the *New England Journal of Medicine*, obese adolescents are more prone to high blood pressure from too much salt in their diet than those who are of normal weight. However, high sodium-related hypertension can be significantly reduced by weight loss.

In the study, led by pediatric cardiologist Albert P. Rocchini, MD, 51 obese adolescents were monitored before and after a 20-week weight-loss program. At the conclusion of the program, the boys and girls who lost weight showed significantly decreased blood pressure readings and lowered sensitivity to dietary sodium.

U-M Med School dedicates two research buildings

Years of scientific accomplishment and collaboration were celebrated in October as the University of Michigan Medical School dedicated Medical Science Research Buildings I and II.

The eight-level buildings provide an important new facility for the Medical School's research laboratories, which otherwise are housed in buildings across the campus, including many buildings that were built more than 30 years ago. These new structures contain 112 laboratories, 125 faculty offices, and 14 conference rooms, as well as animal facilities.

The structures also hold the Howard Hughes Medical Institute, a premier research institute focusing on the clinical application of molecular genetics, and investigators from the U-M Cancer Center and the Departments of Dermatology, Internal Medicine, Pathology, Pediatrics, Psychiatry, Radiology, and Surgery. The U-M Center for Molecular Genetics and shared interdisciplinary core facilities also are in these buildings.

Also housed in these

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buildings will be the Conrad Jobst Research Laboratories, the result of a major gift from Caroline Briggs Jobst to establish cooperative facilities at the U-M and the Toledo Hospital for the research, diagnosis and treatment of vascular disease. Numerous individual donors also contributed support for the H. Marvin Pollard Research Institute, which comprises laboratories dedicated to the investigation of stomach, liver, and intestinal diseases.

Alger, Marquette county schools begin tobacco-free project

Alger and Marquette county school districts have begun a tobacco-free school project, thanks to a $24,600 grant from the W. K. Kellogg Foundation. The project's aim is to help schools develop and promote tobacco-free school policies and create a tobacco-free teen clinic, says Nancy Quaerna-Varline, project director.

"We get many calls from teens desperately seeking help to kick the habit," she said. "In Marquette County, 44 percent of the adolescents who use tobacco stated they would like to quit and need some assistance."

Quaerna-Varline added that higher long-term cessation rates are achieved with group cessation programs. The Tobacco-Free Teen Clinic, developed at universities in Oregon and Minnesota for the American Lung Association, utilize many of the interventions known to help tobacco addicted adults. The Clinic is a four-week-long tobacco treatment program for students wanting to quit cigarettes or smokeless tobacco. Peer issues and nutrition information are utilized to meet the special needs of teenagers.

According to Quaerna-Varline second-hand smoke exposure is more of a health threat to children than to adults. A survey of ninth to twelfth grade Marquette students has shown that 85 percent feel that smoking by school staff personnel influences student behavior and 82 percent would favor a smoke-free policy for both students and personnel on school grounds.

A day-long conference was held at Marquette General Hospital in October for members of the two Upper Peninsula school districts. The workshop was led by Gretchen Griffin from the Minnesota Department of Education who has helped over 260 Minnesota schools develop tobacco-free policies.

The Tobacco-Free School Project is sponsored by the Upper Peninsula Tobacco Or Health Community Coalitions and the W. K. Kellogg Foundation.

Beaumont conducts study of blood pressure drug

Elevated levels of cholesterol and low levels of HDL dramatically increase the risk of coronary heart disease. Researchers have discovered that these levels can be significantly altered by medications used to control blood pressure. Therefore, blood pressure lowering drugs may provide a secondary benefit to patients in the prevention of coronary heart disease.

William Beaumont Hospital's Clinics of Preventive and Nutritional Medicine are conducting a research study of a new blood pressure lowering drug that may help prevent heart disease by increasing the patient's level of HDL, a "good cholesterol" that removes fats from the bloodstream.

Volunteers are still being accepted for the research study. For more information, call (313) 646-6500. ■

Michigan State Medical Society

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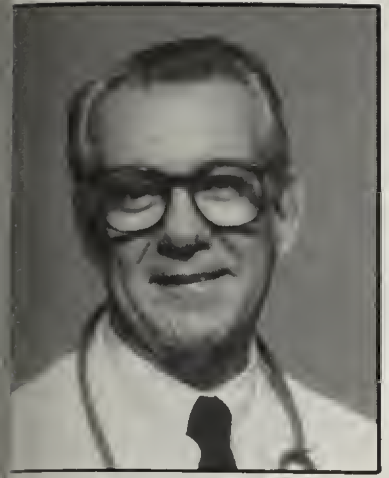

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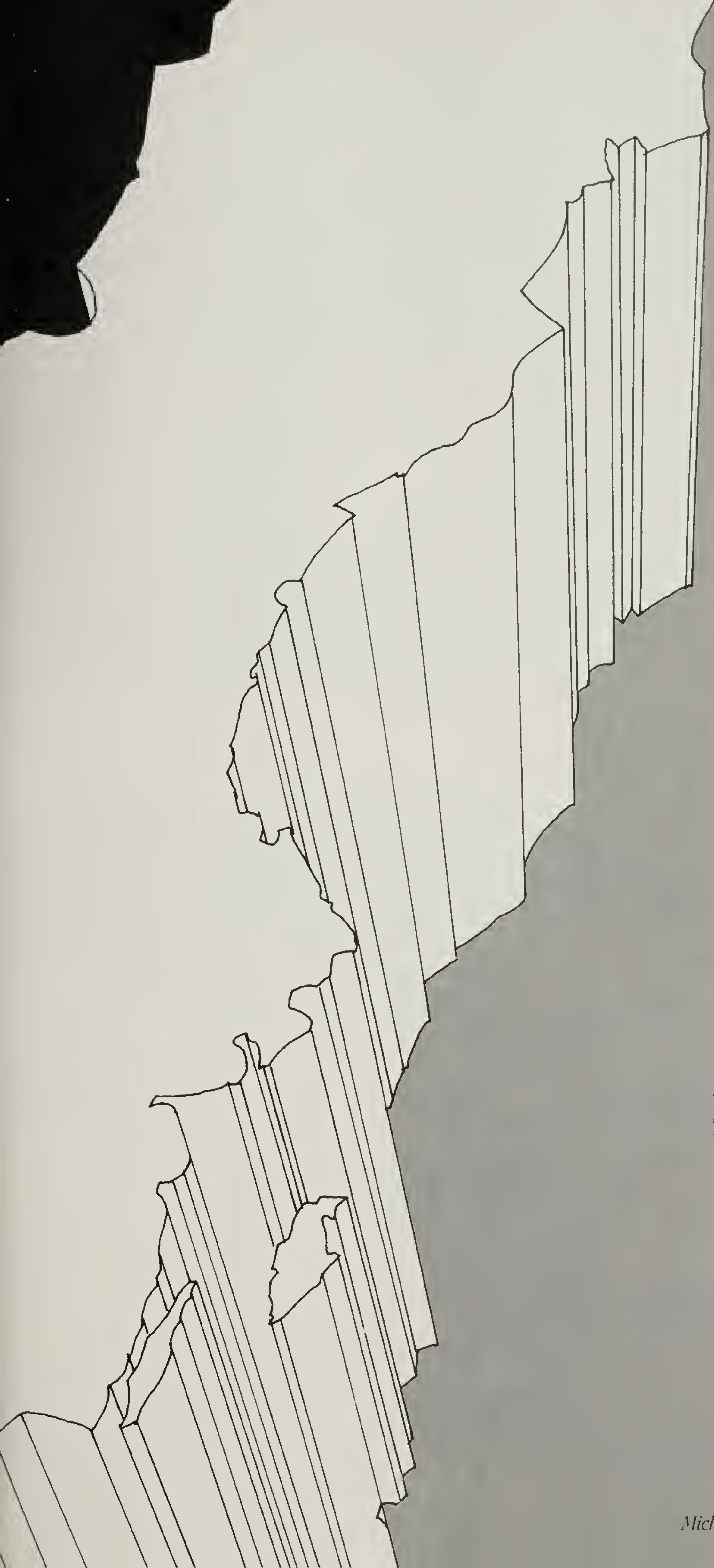

MSMS Takes a First-Hand Look at Sweden's No-Fault Patient Insurance Fund

By Chad Munger

If the goal of a recent excursion to Sweden was to take a first-hand look at the country's No-Fault Patient Insurance Fund, the fruits of the trip were much riper. The 10-day, mid-August trip to Stockholm brought together an unlikely group of professionals, all of whom will play an important role in the future of medicine in Michigan.

The unusual contingent from Michigan included representatives from MSMS, the Michigan House and Senate, the Michigan Trial Lawyers Association, the Michigan Hospital Association, the Michigan Physicians Mutual Liability Company, the Physicians Insurance Company of Michigan, the Michigan Hospital Association Mutual Insurance Company and various other health care experts and educators.

The group saw how a no-fault compensation fund works in one health care sys-

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tem. But beyond that, participants were exposed to the difficulties faced by a social medical system, and an entirely different approach to malpractice compensation and medical discipline. Most important, unlikely new relationships were formed. A point of common reference was found upon which many discussions about the practice and management of medicine in Michigan surely will be centered.

Plans to visit Sweden began nearly two years ago, after a representative of the Swedish Patient Insurance Fund was forced to cancel a lecture visit in Michigan. After this disappointment, MSMS leadership decided that a first-hand experience with the system might be beneficial. In the ensuing two years, many "would-be" participants in the trip examined the Swedish medical system, relying heavily on the work of Marilyn Rosenthal, PhD, a medical sociologist from the University of Michigan (also a participant in the August trip).

Trip worth the expense

"The trip to Sweden was invaluable in a number of ways," says MSMS President Robert E. Paxton, MD, a member of the Michigan delegation. "The diverse group of people that took part never could have been assembled in Lansing, not even for an hour. Living together and going through the socialization process for two weeks provided us with a unique opportunity to learn."

At first glance, the seemingly volatile aggregate of interests brought together by this expedition regarding Michigan's medical malpractice system seem, at best, polar. However, this appearance may be misleading, as MSMS President-Elect Susan H. Adelman, MD, points out.

"The trip allowed people who disagreed, or thought they disagreed, to sit down and talk out their differences, as well as to find out they liked one another as people," she says.

Doctor Paxton concurs. "We found that although some people are very confrontational, we really like each other," he says.

Sweden's solution to medical compensation and regulation is radically different from any found in the United States. It is also a country which has a strong, comprehensive social welfare system, uniquely suited to the path its countrymen have chosen.

Medical coverage in Sweden is a right of citizenship, as the vast majority of physicians are employed by the counties in which they practice. Their standards and conduct are established and monitored by a conglomerate of topnotch health care professionals, and the entire system is supported financially by tax dollars.

Patient Insurance Fund: How it works

The aspect of the Swedish system the Michigan group intended to focus on was a no-fault insurance system known as the Patient Insurance Fund. This no-fault insurance fund is financially supported by tax dollars from Sweden's county councils (counties are roughly equivalents of states in the US). The Fund itself is managed by a group of private insurance corporations known collectively as Scandia.

Participation in the Patient Insurance Fund is completely voluntary; there is no legal restriction preventing a Swede from choosing to take a physician to court. The advantages of using the Patient Insurance Fund, however, are clear. For the patient, the fund provides quick compensation (most claims are resolved within six months), and a consistent level of compensation (the fund uses a pre-determined schedule of awards). In ambiguous cases the claimant is usually given the award and the patient avoids the frustration and expense of going to court. For these reasons very few Swedes choose to take their cases directly to court.

The Patient Insurance Fund uses a predetermined schedule of awards to compensate patients who submit claims. The schedule of awards is based on the extent of injury, thus making awards consistent and reasonable.

A key to success of this system is the great care given to determining criteria for a compensable event.

"Sweden has very carefully defined the compensable and non-compensable event," says Doctor Adelman, "and that is one reason they do not have an enormously larger amount of suits taken to court."

To qualify for compensation a patient must have received an injury which required them to report sick for 30 days, have been hospitalized for 10 days, suffered permanent disability or died. These definitions of compensable injuries exclude minor injuries and psychological injuries as well as injuries which are inherent in some medical treatment, such as chemotherapy.

One other very important incentive for using the Patient Insurance Fund is Sweden's legislated cap on compensation for pain and suffering. Because a cap exists on awards for pain and suffering, extremely high court awards are rare in Sweden. More consistent and acceptable awards are often received through the fund. Physicians and legislators alike on this trip saw the potential for some similar application of a cap in Michigan.

In comparison to a tort system, the Patient Insurance Fund is relatively simple and inexpensive to run. With no need for legal assistance and pre-determined award schedules, administrative costs are radically cut, as is the time it takes to process a claim. Collateral payments are deducted from awards, reducing duplication and overpayment.

Fund's goal the most attractive feature

Perhaps the most attractive feature of the Swedish no-fault fund is its underlying goal — to compensate injured patients for pain and suffering, without vilifying the physician.

"The Swedes believe that it is very important to have good physician/patient relationships that insure good medical outcomes, and this feeling is shared by most physicians in the United States," says Doctor Paxton.

Even though medical leadership in Michigan encourages physicians to pursue a role of advocacy for their patients, they only do so under a cloud of liability issues. The Swedish no-fault approach opens the door to greater advocacy and a better physician/patient relationship.

"I think that there could be a similar fund in our system that one could apply to without pointing the finger at the health care provider," says Doctor Adelman.

Treatment of medical discipline creative

Equally as creative as Sweden's no-fault approach to compensation, is its treatment of medical discipline. In Sweden, claims of malpractice or negligence made

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Bo Hjern, MD, chief executive officer, Swedish Medical Association, addresses participants in the Stockholm Seminar at the Swedish Medical Association Headquarters. The seminar was held August 13-23, 1989.

Photos by: Thomas C. Payne, MD

MSMS President Robert E. Paxton, MD, (right), asks Jan Sahlin, (center), legal advisor, Federation of Swedish County Councils, and Ann-Cathrine Haglund, (left) a member of the Swedish Parliament, some hard-hitting questions about the country's medical liability system.

Gunner Lundquist, international secretary, Swedish Medical Association, (shown standing), addresses seminar participants at the Swedish Medical Association Headquarters in Stockholm.

Seminar participants travelled to the office of the Medical Responsibility Board to discuss the Board's role in the Swedish Medical Liability System. The Medical Responsibility Board, a free-standing national governmental body supported by public taxes, receives complaints about all health professionals, 80 percent of which concern physicians.

against a doctor are handled by a governmentally-appointed group of consumers and physicians known as the Medical Responsibility Board (MRB).

The Medical Responsibility Board is rather unlike its nearest Michigan counterpart, the Board of Medical Discipline. The MRB is a government-run agency in Sweden, supported by public taxes. The unique feature of the MRB is the composition of its board, where only one of nine members is a physician. The rest are representatives of Swedish Parliament, large unions and county councils. Because of the excellent consumer representation on the board, it enjoys wide support both in and out of the professional medical community.

The MRB is supported by a staff of 20. When a complaint is filed and investigated by the MRB, a physician (usually considered to be one of the top in the profession) is chosen to investigate the complaint. This physician conducts the investigation and makes a report to the MRB. The Board has a wide range of sanctions which it may levy against the provider if deemed necessary, including revoking the license to practice.

In their disciplining of physicians, the Swedes have demonstrated an unusual philosophy — that is to keep a physician working. Often a finding in a complaint against a physician will lead not to a complete removal from the health care system, but rather a change in positions; for instance, the physician may become a medical technician. The emphasis is on keeping the individual employed and productive, quite a departure from the American approach. The MRB also takes more per capita actions against physicians than do American disciplinary boards, indicating it may be more effective.

The advantages of this type of disciplinary system were not lost on members of the trip. Of all the aspects of the Swedish approach to health care which were examined, this may be the one most readily adaptable to Michigan. As Doctor Paxton points out, "One of the most important things for physicians in Michigan is strengthening our medical boards and the way we discipline physicians. We must do this if we are to make a move to take this issue out of the courtroom. This may mean increasing consumer participation in our medical board, but this does not frighten me any more after seeing the way it works in Sweden."

The success of the MRB seems to be a result of the quality of physicians taking part in the board's activities. Improving the performance of physicians in our own system is obviously a goal of Michigan physicians.

"Wouldn't it be interesting," comments Doctor Adelman, "if (Michigan) courts could appoint a physician consultant to be the court expert in malpractice cases and bar either side from appointing an expert witness. If the court could appoint a physician from a panel selected in conjunction with MSMS and other professional societies, we would then be saved from all the problems we face with 'experts' being underqualified."

Other benefits of the Sweden visit

Although it was not the primary purpose of the trip, seeing a working example of a completely social medical system was certainly one priceless outcome. Doctor Paxton points to this experience as one of the trip's most valuable.

"I think the fact that we were able to bring with us some very important legislators who could see for themselves the problems and failures of a socialized medical system was of great value," he says. "With the big push in Michigan for a universal health care system, it was good to see a system with very little privatization pushing for more. It was a very timely trip."

Marguerite Shearer, MD, member of the MSMS Board of Directors, agrees. "It takes 12 to 18 months to get an orthopedic consultation and three to four years to have a coronary bypass in Sweden. We need to look at these types of net results caused by a social medical system before moving ourselves."

"I don't think any of us expected to go over and bring back a template to throw over the system in Michigan," says Doctor Paxton.

Though the Swedish system as a whole may have little value in Michigan, certain components may find applications somewhere in the system. Perhaps, as Doctor Shearer suggests, a modified liability system for dealing with the uninsured could improve access to care. Regardless of any immediate systematic fall-out from this experience, the trip inspired a bit of creative thinking and a more open mind in all who went.

"If we didn't gain anything else from this trip, we will never get the chance to be so close to senators and representatives again, and that has already paid off," says Doctor Paxton. Already in meeting rooms, professional offices and social events around the state, doctors and lawyers, senators and hospital administrators now can do much, "Hi, how are you-ing," that was never before possible. It is this type of relationship that must be fostered to bring resolution to the difficult problems facing Michigan's medical future.

Says Doctor Paxton: "We need to come up with alternatives, to be proactive. I think trips like this one help develop that kind of thinking and activity." ■

Chad Munger is a Chicago-based freelance writer.

Cover Story

Can the Swedish System be Transplanted? Probably Not, say Hospital Execs

By Michael R. Schwarz and Peter A. Wilson

Sweden almost has the same number of people as does the state of Michigan. After that, similarity declines. Therefore, it is not surprising that we conclude the Swedish systems for dealing with medical liability probably cannot be transplanted to Michigan. What is surprising is how successful the Stockholm trip was in stretching our thinking and suggesting avenues of approach that may be helpful in improving Michigan's approach to medical liability. We extend our thanks to our Swedish faculty and to our seminar colleagues for all they taught us.

The Swedish way of life

The eight-and-a-half million Swedes live in an area about three times the size of the state of Michigan. They have an average per capita income of about $20,000, which is quite close to the United States, but that income appears to be much more uniformly distributed with few obvious signs of poverty.

The general feeling one has when walking the streets of Stockholm is that the standard of living is at least comparable to that in the United States.

The economy appears to work and is based on the export of research intensive industrial products. Every Swede is guaranteed five weeks vacation by law on top of which his or her bargaining unit adds whatever it can. There are an extraordinary number of reasons for being legitimately absent from work, with the result that, on any given day, close to 50 percent of the labor force is not on the job. Unemployment is virtually nonexistent, although productivity is a concern.

Swedes appear to be generally satisfied with the functioning of their social and economic system although it is based upon tax rates that most Americans would find depressing. The key appears to be that most Swedes are satisfied with the vast array of services that government provides based upon tax revenues.

While Swedes face a top income tax rate of 80 percent and a 24 percent value-added tax (like a sales tax), they are supported by an extraordinarily comprehensive safety net. Some of the more notable and relevant features of that net include national health insurance, a lost income sickness benefit at 90 percent of earnings, parental leave of one year, a child care allowance, a housing allowance, free university education, and on and on.

Compared to the United States, Sweden is a very homogeneous society with less of a belief that an individual's economic and social success or failure rests with the individual and is only to a limited degree a matter of government or societal responsibility.

The Swedish system

Our ten-day seminar was designed to look at three aspects of the Swedish system for dealing with medical liability:

1) A Patient Compensation Fund to assist patients who have suffered unexpected injury through medical treatment.

2) A Medical Responsibility Board whose job it is to discipline all health care personnel (not just physicians).

3) Institutional systems for risk management and quality assurance.

Patient Compensation Fund

In Sweden, a more or less complete distinction is made between the system that handles patient compensation and the system that handles professional discipline. It is interesting to note that the Patient Compensation Fund was begun in 1975 with the main intent being to increase payments to "victims." Prior to this time, obtaining compensation through the tort system — based upon establishing "fault" — was very difficult. That stands our Michigan situation on its head.

Using the Patient Compensation Fund is voluntary on behalf of the injured party. The alternative of using the court system is always available, but since the schedule of damages is less generous, it is not used very much.

The Patient Compensation Fund utilized a contracted private insurance company consortium with dedicated staff plus highly qualified medical consultants to establish the fact in each case. The system is not exactly "no fault" because it does not cover every unfortunate outcome, but only those outcomes that are unexpected given the medical condition of the patient and the treatment undergone.

It is important to keep in mind that the amounts of money distributed through the Patient Compensation Fund are relatively modest by Michigan standards. The annual expenditure is less than $15 million as compared to an estimated $450 million annual cost for medical liability in Michigan. The primary reason for this is that most of the Fund's payout is only for pain and suffering, which is scheduled at a very modest level. Economic damages, primarily medical expenses and lost income, are covered under the general social safety net.

Whether because of the relatively modest sums involved, the defined benefit schedules, or because of different assumptions about the role of courts in society, the Fund in general and the details of its working assumptions and premises do not seem to draw much legal challenge. One area of current controversy is over the level of benefits available through the Patient Compensation Fund. A specific case in point is whether the Fund should pay for round-the-clock at-home nursing care in the case of a patient who suffered damages as the result of obvious low quality care. Under the standard national health benefit and system, such care is only available in an institutional setting.

Medical Responsibility Board

The Medical Responsibility Board operates independently of the Patient Compensation Fund to the extent that there appears to be very little by way of formal, or even informal, exchange between the Compensation Fund and the disciplinary activities. Sanctions available to the Board include practice restrictions, warnings and admonitions, and recommendation to the proper authority that a license be revoked.

The Board appears to be widely credible, both within the health care professions and amongst the general public. In part this may be because the Medical Responsibility Board has a consumer majority, but in part it may simply reflect the fact that Swedes appear to be less skeptical about the workings of their institutions.

Risk management and quality assurance

This was probably the most underwhelming part of the seminar and potentially one of the most disturbing. While we had an admittedly brief and narrow exposure to the state of the art in Sweden, what we saw was not remarkable. Our Swedish hosts seemed to generally think that the United States is substantially ahead in this area, and nothing we saw gave us any reason to doubt their judg-

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ment. The minimization of adverse outcomes is a much wider question than the functioning of professional disciplinary boards. The lack of financial incentives to encourage risk management and quality assurance, coupled with the absence of market incentives or any organized efforts under the heading of professional responsibility, leave Sweden behind the curve.

Was the trip worthwhile? Absolutely.

Can the Swedish system be transplanted to Michigan? Probably not.

The benefits of the experience have to be credited to two accounts: the relationships forged among the seminar participants, and the new ideas and approaches that were stimulated. These advantages converge in the current work being undertaken by the Michigan Hospital Association-Michigan State Medical Society Joint Committee on Alternatives to Tort.

Many of the committee members were on the seminar and came away with a renewed sense of the importance of developing positions for medical liability reform which address the concerns of patients, physicians, hospitals and lawyers. The committee is currently engaged in developing a proposal for medical liability reform which incorporates many of the positive aspects of the Swedish model. It will be a system which allows the plaintiff and defendant to adjudicate their dispute either in the courtroom or by way of an administrative mechanism. Upon establishing fault in either venue, a schedule of economic and non-economic benefits would apply. The hope is to create a system which minimizes transaction costs, both time and money, while leading to more predictable, timely and rational assessments and payments of damages.

As this new approach works its way through the legislative process, it can be hoped that the relationships that developed between and among physicians, hospital administrators, members of the State Bar, and legislators will assist us all to adopt a larger perspective and make the careful compromises through which the public interest is served. ■

Michael Schwartz is the executive vice president of Mercy Health Services, Farmington Hills. Peter Wilson is senior vice president of the Michigan Hospital Association.

Michigan Insurers Speak Out on Sweden's Medical Malpractice System

By Chad Munger

The frustration of exorbitant and seemingly random malpractice awards being gobbled up by Michigan's legal system is as confounding to insurers as it is to physicians.

William Cheeseman, president of Michigan Physician's Mutual Liability Company (MPMLC), echoes the frustrations facing insurers.

"MPMLC stands for fairness and equity in the marketplace," he says. "What is so troublesome to us is that we administer a system where 60 cents of every dollar doesn't go directly to the person who was harmed in a malpractice suit." This shared frustration is one reason insurance companies associated with the Michigan State Medical Society and the Michigan Hospital Association have joined in the search for alternatives to Michigan's often fickle compensation system.

Almost all physicians buying insurance in the private market are covered by MPMLC, Physicians Insurance Company of Michigan (PICOM), or the Michigan Hospital Association Mutual Insurance Company (MHAMIC). Representatives from all three groups travelled to Stockholm last August to study Sweden's Patient Insurance Fund.

For these three insurers, interest in a new compensation system is a recognition that the current system is lacking, specifically in consistency and what many individuals feel is a fair distribution of payments.

As insurers, money is not the motivation to seek change. A new system is not likely to generate a good deal of additional income for them. An approach similar to the one found in Sweden, although less costly to administer, would not change premium rates if applied here in Michigan.

"We weren't there with a real self-interest in mind," says Victor Adamo, president, Physicians Insurance Company of Michigan. "I think that, in addition to our desire to be properly run insurance companies, (MPMLC, PICOM and MHAMIC) each feels it has a mission to make medicine and hospitals practice better and to make the system a better place in which to deliver patient services."

Everyone who took part in the trip agrees that, from an insurer's point of view, the Swedish people have developed a very positive approach to malpractice compensation; they also agree that Michigan is not Sweden.

Like the physicians who took part in the trip, representatives from the insurance groups recognize that, as a whole, the Swedish system cannot be transplanted to Michigan.

"What really makes the compensation system in Sweden work isn't the laws or the rules of the system, it's an attitude, an attitude shared by the entire population about personal responsibility, liability and social issues," says MPMLC's Cheeseman. "Attitudes are much different over here. When they (Swedes) get up in the morning they are not looking for ways to sue people. That's why bringing back their system, or even major parts of it, would not work here. You would have to bring back a new way of thinking along with it."

Jacque Sammett, president of Michigan Hospital Association Mutual Insurance Company (MHAMIC), supports this position, but points out that the Swedish experience can "provide insurance groups with a guide to creating a better compensation system."

A schedule of benefits for malpractice claims

In particular, Sammet points to a schedule of benefits for malpractice claims as an idea that might be adapted to Michigan's system.

"We are interested in some modifications in our compensation system in Michigan," he says. "Although the modifications cannot be modeled directly after the

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Swedish system, it will have a schedule of benefits as an important factor in it."

Thomas R. Berglund, MD, chairman of the MPMLC Board of Directors, shares a similar point of view.

"Our system (of determining compensation) is horribly unfair right now," he says. "I think that we have to get things out of the courts. For any system like that to work there will probably have to be a schedule of benefits involved."

Reduction of collateral payments a possibility

One other emphasis of the Swedish approach which may someday find a home in Michigan's compensation system is the reduction of collateral payments.

"In Sweden, collateral payments are very carefully extracted from the malpractice issue," says PICOM's Adamo. "The Swedes deal purely with pain, suffering and extraordinary losses. That makes the most sense from an insurance point of view."

Adamo points to California as one example of successfully limiting collateral payments in a tort system. "I think that eventually legislators and the public at large will realize that the system is just too expensive to pay costs twice," he says.

Changes in Michigan's current compensation system will probably not be reflected in higher or lower premium rates for physicians or individuals. The difference will be seen in the distribution and amount of awards, says PICOM's Sammett. "We are talking about changes which theoretically deliver benefits on a more equitable basis, at a substantially lower administrative cost." A modified system might not be substantially cheaper than the court system used now, but the money spent on legal fees and court time would be redistributed to claimants, making payments more appealing and a schedule of payments more consistent.

Redistribution is something physicians, patients and insurers alike would benefit from, says MPMLC's Cheeseman. "If more of what we (insurance companies) collect can go to the patient then it makes us all feel better." ■

Chad Munger is a Chicago-based freelance writer.

Malpractice Reform: Time for a New Approach, says Trial Lawyer

By Barry D. Boughton

The medical malpractice lawsuit occupies an important place in our society. It reflects our values of justice and fair play by providing compensation for death or injury wrongfully inflicted. Lawsuits help identify unacceptable medical behavior in specific factual settings and result in improved care for other patients. This is especially important during a time when many are experimenting with new and less expensive health care delivery systems.

The possibility of a lawsuit and the disruptions and publicity which accompany it, provide strong incentives to provide better medical care. Lawsuits force public disclosure of unsafe practices — drug side effects, unnecessary surgery, among other things — and allow dissemination of important information to the public.

Lawsuits establish rights and duties which not only bind the parties, but also develop a body of law which defines the relationships and duties between physicians and their patients. The constitutional right to sue and to have a jury trial, the contingency fee agreement, and modern rules of discovery, create a fair arena in which to resolve important patient care issues.

Not surprisingly, physicians do not like being sued. They dislike the impact on doctor-patient relationships, turning their records over to attorneys, giving depositions, facing expert critics, being cross-examined, going to court, and paying liability insurance premiums.

Physicians have said often and loudly that they want better protection from malpractice lawsuits. In 1986, the legislature acted to meet that demand. The so-called tort reform required drastic concessions of malpractice victims including damage caps; no access to court without an affidavit of merit; mandatory participation of medical personnel in mediation; limits on use of experts; involuntary periodic payment plans following judgments; loss of collateral benefits; and shortened statute of limitations.

Preliminary experience suggests these changes have provided limited protection to physicians, but that protection has been achieved at substantial cost to the victims of malpractice.

Continuing dissatisfaction among Michigan physicians resulted in plans for the Stockholm Seminar in August, 1989. Its purpose was to discover whether Sweden's Patient Insurance Fund provided an attractive alternative to the malpractice lawsuit.

In 1975, the Swedish County Councils, which own virtually all the hospitals and employ most of the medical licensees, adopted the voluntary Patient Insurance Fund. Their objective was, without requiring proof of fault, to provide payment to patients sustaining treatment injuries that could or should have been avoided with careful care.

In addition, the Swedes wanted to avoid the lawsuit with its high costs and attendant damage to the doctor-patient relationship. To accomplish this, they offered an alternative to the lawsuit which promised to pay benefits that were more generous than could be obtained through the traditional lawsuit. As proof that theirs was the better alternative, they did not demand that the victim's right to "go to court" be curtailed in any way. Under the Swedish plan, the victim is free to choose either alternative. In practice, virtually all claimants select the Patient Insurance Fund because, in fact, the benefits it provides are superior to those that can be obtained by a lawsuit.

Should Michigan adopt Sweden's system?

Should the Swedish Patient Insurance plan be transplanted to Michigan? Unfortunately, this question does not have a simple answer. Adoption of systems developed by foreign cultures presents problems, as Ruth Sidel said:

> "While we use cross-cultural comparisons to stimulate our thinking, to broaden our perspectives, to see the world and its problems in new ways, we must always keep in mind that every society's political and economic system has evolved out of its history; its geography; its ecology; and of the social, political, and economic forces indigenous to it. Policies or solutions or patterns that work for one country may simply not be effective when transplanted to another. Each society must develop its own way, its own solutions that stem from its needs, its history, its values, its goals." (*Sidel,* What is to be done? Lessons from Sweden, Swedish Information Service, 173, 1986.)

The major drawback to the Swedish approach is that the amount of compensation provided is a small portion (less than ten percent of the total damages incurred as a result of malpractice.)

First, virtually all economic losses (wages and medical) are paid by the extensive Swedish social welfare system.

Second, not all Swedish victims of malpractice are entitled to receive compensation. To qualify, the injured person must have: 1) been off work for a minimum of 30 days; 2) have been hospitalized for at least ten days; 3) suffered permanent disability; or 4) died.

In addition, the injury must arise from what is called a "treatment" injury. In general, treatment injuries are those that result from improper or incorrect medical care. If the injury was unavoidable because it was the natural consequence of the basic illness, no money is paid. Also, if the injury resulted from a treatment that was medically motivated (i.e. necessary, but risky), no compensation is paid.

Even more disconcerting is the fact that, during the claims review process, the victim has little or no input. The initial review and decision is made by an insurance claims adjuster. The adjuster has access to legal advice and expert medical consultants. The victim has no practical access to either medical or legal advice. Appeals are submitted to a six-member board which is effectively controlled by the responsible parties and their insurance carriers. In practice the board seldom reverses the adjuster's decision. In Sweden, 50 percent of all the claims are denied.

The compensation paid for pain and suffering is extremely low. Pain and suffering damages are paid only during the acute illness. In no case are payments for pain and suffering paid for longer than 12 months. The most severe injuries, such as crushing, lacerating, or burning injuries, severe skull or face injury, substantial lesions on different parts of the body, and fractures which are difficult to heal receive compensation of only $3,142.86.

Swedish compensation for permanent disfigurement and permanent disability is likewise inadequate. The maximum amount paid to a victim who becomes totally disabled for life is a single lump sum payment of $79,365.08. If the victim is over 25 years old or the degree of disability is less than 100 percent, the payment is reduced accordingly. Concern in Sweden over these paltry sums has led to the creation of a national commission to study this problem.

Given these drawbacks, one might wonder how the Swedish plan survives? The most probable answer is that the Patient Insurance Fund provides an attractive alternative to the Swedish lawsuit. The benefits provided, although small by American standards, are better than the benefits the Swedish victim can obtain by suing in court. The proof that the Fund provides better benefits is that the door is left open to sue in court for any victim who believes the court will provide better benefits. Very few persons select that alternative.

The issue for Michigan physicians is complex

The issue for Michigan physicians who want protection from lawsuits is whether they are prepared to follow the Swedish example by providing malpractice victims an attractive alternative to the traditional American lawsuit. If they are prepared to support a new approach that will provide better benefits and compensate more victims, then victims will have no need or desire to resort to the lawsuit.

Until now, physicians have been unwilling to depart from their past practice of seeking protection from lawsuits by demanding more and more concessions from victims. Not only has that approach failed to provide the protection physicians desire, it has been unfair to those who can least afford it — the victims of medical malpractice.

The lesson of the Stockholm Seminar is that malpractice reform does not need to be accomplished at the expense of the victims. ■

Barry Boughton is an attorney with Sinas, Dramis, Brake, Boughton & McIntyre, PC, Lansing.

Cover Story

"There are no cure-alls to our problems," says Rep. David Gubow

The following is an excerpt from a speech delivered by Representative David M. Gubow to the Oakland County Medical Society at its annual meeting on November 1, 1989.

Before this past summer's trip to Stockholm I knew very little about Sweden or Swedish history. I was one of those people ready to return to Europe at a moment's notice, but never even giving Scandinavia a second thought.

Continued on page 24

All I knew was that this was the land of the Midnight Sun — where Vikings came with a culture of slaughter and feasting, where people called Lapps raised reindeer, and where everyone had blond hair and blue eyes.

Little did I know that even though it is easy enough to find parts of Sweden that correspond to all these stereotypes, Sweden is a very modern country with a high standard of living, it is a prosperous, democratic and neutral country with a history of an unbroken peace, economic stability and relatively high educational standards.

The Swedish mindset

So you can get a better understanding of the Swedish mindset in creating its medical discipline and liability systems, I offer the following points:

First, even though there are five political parties, most Swedes identify with only one — the Social Democrats, which has shaped modern Sweden.

Second, as far back as one can go in history, Sweden has been a homogeous nation. Until after World War II there were very few immigrants. Today, approximately one of every eight children growing up in Sweden is of immigrant descent.

Third, the rate of unemployment is below two percent. And unionization is very high. Ninety percent of all blue collar workers and 85 percent of all white collar workers are union members. Even 25,000 of the 30,000 medical doctors in Sweden are union members.

And fourth, Sweden, with a population of little less than that of the State of Michigan, spends a considerably high percentage of its central government budget on health, education, cultural and social programs. Only 8.5 percent go to defense, compared to the allocation of 31 percent of the United States federal budget for defense.

These are all-important things to keep in mind, not only in seeing how the so-called Swedish no fault and disciplining systems came about, but also in seeing how they operate.

No easy solutions

I went to Sweden as chair of a Special Ad Hoc Committee looking into ways to improve the licensing and disciplining of doctors in Michigan. I thought that if I could ask the right questions that our problems here in Michigan would be over. So ask away I did, only to find that there are no cure-alls to our problems; that because of cultural, political, and a variety of other reasons, including their system of national health care, their system cannot be totally duplicated here.

In creating their no-fault system the Swedes not only were dealing with the doctors' desire to avoid lawsuits, but the patients' desire to be compensated. Matter of fact, we were told that they made the assumption that "liability is good, but what is liability if the liable person can't pay?" Therefore, they were actually trying to take care of the consumer. They wanted to make it more desirable for a person to go into this new no-fault system than to go to court. To do so would mean that the injured person would have to get their money quicker, when they are actually in financial need. It would have to cover not only the clear cut cases of malpractice, but the gray areas as well. It would mean a compensation scheme that was more liberal with higher awards than you could obtain in court. Therefore, it was going to cost more money, not less, to change the system from one of defense of doctors to one of compensation of patients. This concept could be difficult for some to accept. But the doctors felt that not being personally sued and not having to appear in Court was well worth the extra costs that would have to be paid by their employers — the government. With the Swedish system, the doctor-patient relationship is maintained and the doctors actually become the advocates for their patients in these cases.

As an aside, I might also point out that the general consensus, even among doctors, is that the patients' compensation is too low and should be raised.

Also at work in Sweden is something called the Medical Responsibility Board. The public was of the belief that everything was controlled by the doctors and that no doctor would ever testify against another. Whether true or not was irrelevant. But to deal with this public perception, the Medical Responsibility Board was created and the influence of the public strengthened. Matter of fact, there is only one doctor on the board and he and the other doctors I spoke with are very satisfied with this arrangement.

I personally feel that for all the hard work and effort put in by the Medical Responsibility Board it actually does very little to discipline doctors or remove bad doctors from the system. We were usually told that when identified the bad doctor was simply put somewhere in a hospital where he could not do any harm.

But despite my impression of ineffectiveness, the Board has a very positive public perception in Sweden, for it gives patients a place to complain. It does nothing for quality assurance. It cannot act in an emergency or act on its own. The Board can only deal with a very few of the actual mistakes committed. As one doctor put it, there is more "underwater than above." But it does have a very positive public perception of effectiveness. And that is very important.

Many lessons learned

Was the trip worthwhile? And, where do we go from here? Even though I did not find all the answers I was looking for, I personally learned a great deal from the Swedes: not just what they do, but also what they do not do. This experience has aided me in developing a new licensing and discipline system in Michigan. Our goal will be a system that is streamlined, without delays, that is effective, that provides for quality assurance and most of all is fair to the doctors while providing a positive public perception that it is effective and that the bad doctors are being eliminated from the system and the consumer protected.

Finally, one of the most positive things that came out of the trip was something that is difficult to measure. That is an atmosphere that brought together doctors, legislators, hospital and insurance company representatives, as well as plaintiff's trial lawyers. Each was able to meet and discuss matters in a non-adversarial setting. People found out that they actually had a lot in common. This point alone will prove most beneficial as we continue to work on improving the licensing and discipline system and continue to explore alternative dispute resolution systems. ■

David M. Gubow is a Huntington Woods democrat.

Cover Story

Swedish System Gives State Legislator a New Perspective

By Rep. Richard A. Bandstra

Since returning from Sweden with the MSMS-sponsored delegation, I often have been asked my impression of our trip. I always respond that it was a worthwhile experience. I gained insights into the Swedish system which should be helpful here in Michigan now and in years to come.

If is often easy for policymakers, stuck in their own system, to forget that wholly different approaches are possible. The Sweden trip opened our eyes to new possibilities for physician discipline and patient injury compensation. Our schedule included seminars with top officials from Sweden's Board of Medicine and Patient Insurance Fund. Our diverse delegation (ranging all the way from attorneys to doctors) asked plenty of questions and received honest responses. We learned a lot in a short time, thanks mainly to the organizational effort of MSMS staff, the wisdom and contacts provided by our mentor, Marilyn Rosenthal, PhD, and the gracious hospitality of our Swedish hosts.

Patient Insurance Fund

As a veteran of recent legislative battles on malpractice reform, I found the Swedish Patient Insurance Fund especially intriguing. The Fund compensates patients suffering an injury as a result of medical treatment. It does this at a fraction of the cost Michigan doctors pay for malpractice insurance. Might this kind of approach work here?

I believe our delegation generally agreed that the Swedish Patient Insurance Fund simply cannot be snipped out of Swedish society and pasted onto Michigan's. The cost of the Fund to medical providers is reduced because of a number of factors unavailable here in Michigan. First, the Swedish Fund makes awards to patients to assure compensation after payment is received from other compensation sources. Sweden has a wide panoply of government-run, tax-supported insurance plans which basically cover lost wages and medical care costs. As a result, the Patient Insurance Fund, in practice, really only awards compensation for pain and suffering damages.

Further, with respect to those pain and suffering awards, levels of payment are low compared to amounts provided through Michigan court actions. Swedish pain and suffering compensation levels are based on jury awards rendered before the Patient Insurance Fund went into effect. Those jury awards reflected a more conservative approach to this kind of damage. Accordingly, they are low by Michigan standards.

This is not to say that anything akin to the Swedish approach will be forever impossible here in Michigan. For example, the advent of universal health care coverage would certainly facilitate an approach similar to the Swedish Patient Insurance Fund. So would re-opening of the debate on a cap of some sort for pain and suffering damages.

Physician discipline

In addition to the Patient Insurance Fund, our delegation reviewed Sweden's physician discipline mechanism, the Board of Medicine. This was of immediate interest to fellow traveler Representative David Gubow and me. We serve on a House Ad Hoc Committee which soon will be recommending changes to the Michigan physician discipline system.

Our Swedish hosts were most proud of the public confidence that their disciplinary system apparently generates. To a large extent, they consider this the result of the makeup of their Board of Medicine. Compared to the Michigan physician discipline panel, the Swedish Board includes more "consumer" representatives and fewer medical personnel. As a result, the general public feels their interests are well represented. The process is not perceived as being designed to protect the doctors against whom patients complain.

At the same time, Swedish physicians we spoke with felt that the Board's investigatory process includes sufficient medical perspective and insight to assure a fair result. Each case of alleged physician misconduct is prepared for Board review by a physician from the same specialty under review. Further, the opinion of the physician representative on the Board is generally persuasive for non-medical members.

Many other states are changing the composition of their physician discipline review boards to provide broader nonphysician representation. The Swedish experience shows that this can be accomplished without sacrificing appropriate professional input and a fair result.

All of us, especially public policymakers, can easily forget that our way of doing things is not the only way available. The Sweden trip opened many of our eyes to see the possibilities that exist for immediate changes and changes that may occur down the road. I commend MSMS for taking the lead on this important venture. ■

Rep. Bandstra, a republican, represents District 93, Grand Rapids.

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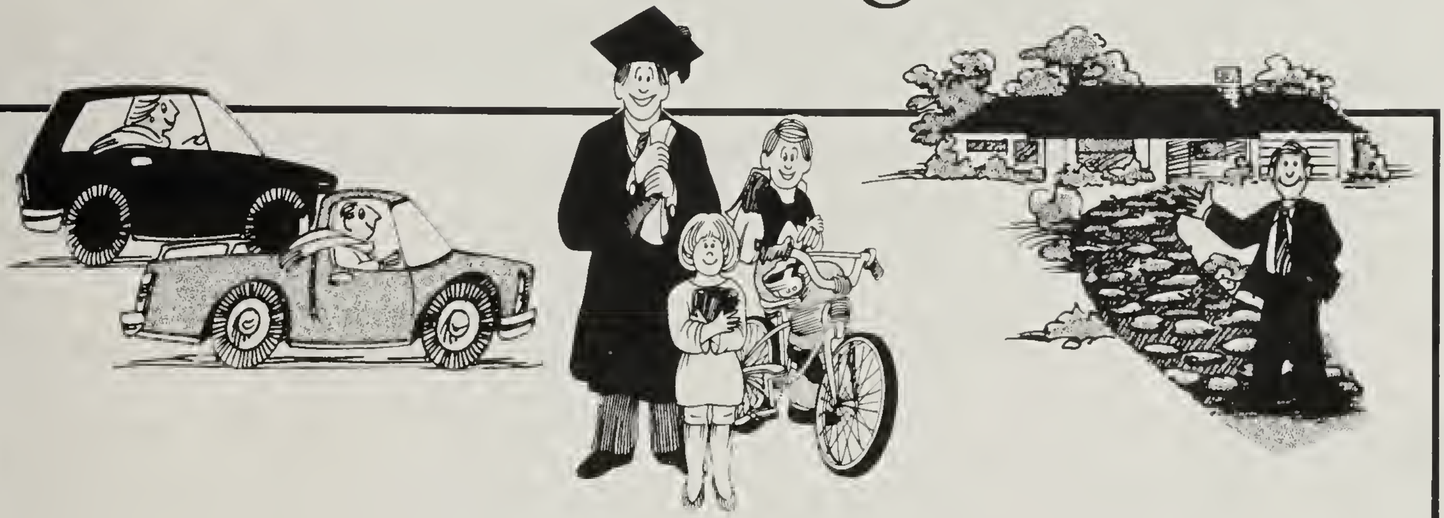

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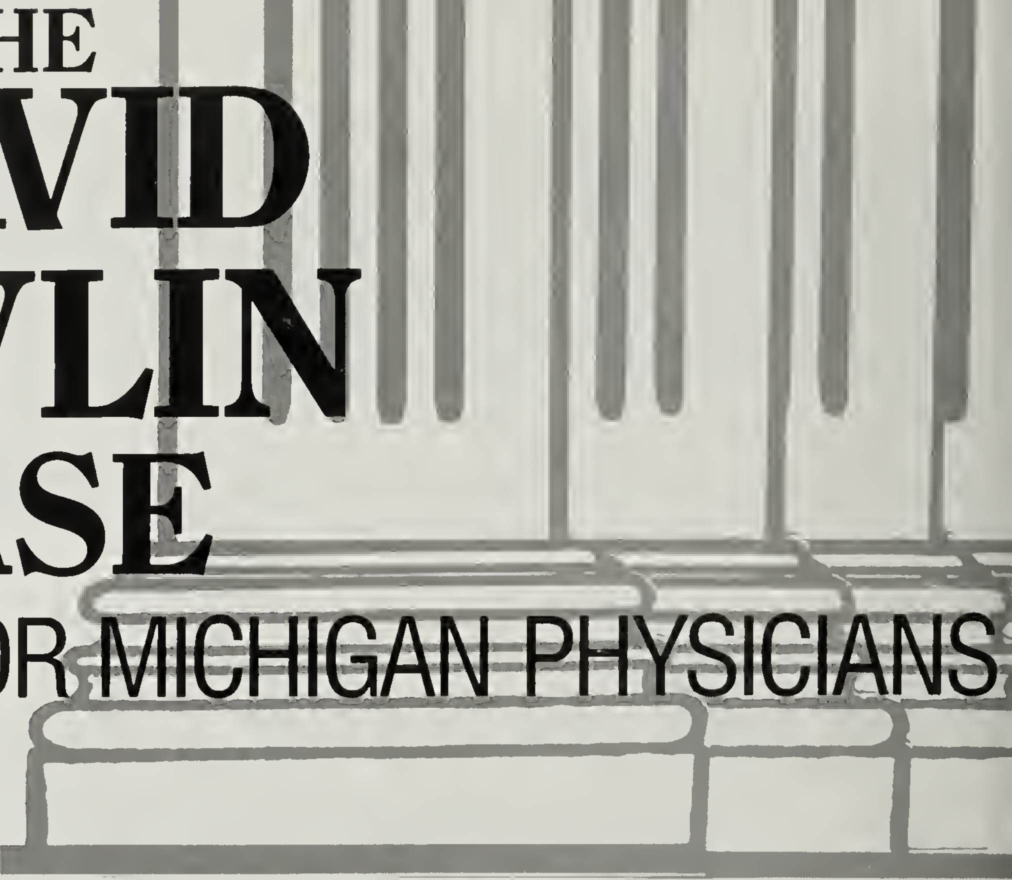

By Howard A. Brody, MD, PhD and Fred W. Bryant, MD

Between May and July, 1989, the news media in Michigan focused attention on the dilemma of David Rivlin, a quadriplegic desiring discontinuation of respirator use in a nursing home, with the probability of death as a result. An Oakland County court considered his request and refused to block it. Rivlin died at the end of July. During the August 16th meeting of the MSMS Committee on Bioethics, the implications of this case for Michigan physicians were discussed. Following is a summary of that discussion.

Facts of the case

David Rivlin became quadriplegic as a result of a diving accident in 1971. In recent years he suffered progressive physical deterioration prompting the use of a ventilator. A complex interplay of factors that included diminished family support and limited rehabilitation services led him to conclude that ending his life would be preferable to surviving totally machine-dependent with no prospect of recovering any function.

Mental health experts examined Rivlin and determined that he was rational and capable of making the decision to cease machine ventilation and was aware of its consequences. However, the attending physician at the nursing home and the nursing home administration declined to honor his request. This led Rivlin to file suit in Oakland County court; the request was unopposed.

On July 5, Judge Hilda Gage deliberated the case and refused to issue a ruling. Her rationale was that Rivlin's petition conformed to a firmly established principle of law that competent patients have the right to accept or refuse medical treatment, including life-sustaining treatment. The judge felt it was so obvious that Rivlin had the right to carry out his expressed wishes that no judicial ruling was needed.

Following this ruling, Rivlin located a physician (unnamed in the media) who was willing to carry out his request. He was transferred to a private home, and the respirator eventually was turned off. Rivlin died peacefully in the company of friends.

Implications of the case

The Rivlin case becomes the fourth known Michigan court action (or inaction) in so-called "right to die" cases, three of these occurring in Oakland County.

The cases of James Blodgett and Clifford Culham involved patients judged competent who sought to terminate the use of a ventilator. Blodgett's case was similar to Rivlin's; Culham had progressive Amyotrophic Lateral Sclerosis. In both cases, lower court judges upheld the patient's right to refuse treatment and ordered that physicians and health institutions be held immune from liability if they carried out the patient's wishes.

The third case, that of Joelle Rosebush, involved a respirator-dependent twelve-year-old child in a persistent vegetative state in which the parents requested termination of the use of mechanical ventilation. The parents' right to refuse medical treatment was upheld by an Oakland County judge; however, the case is currently under appeal.

Various national consensus reports on medical ethics have supported the principle that competent patients have the right to refuse medical treatment. US courts generally have reached similar conclusions. Rare exceptions have challenged treatment refusal sought by families or others on behalf of incompetent patients, but virtually never dispute the right of competent patients to determine treatment for themselves.

MSMS viewpoint

Initially, some MSMS officials expressed some surprise and regret that Judge Gage had not explicitly ruled in favor of Rivlin's motion, thus clearly conferring immunity upon physicians and others who carried out Rivlin's wishes.

Upon reflection, the MSMS Committee on Bioethics feels that the *refusal to rule* in this case has two positive features. First, a ruling would have invited similar petitions from other patients or physicians, and might have sent a message to the medical community that one dare not withdraw a ventilator in Michigan without prior court approval, thereby inserting an additional (and unwelcomed) step into the process. Judge Gage put the case in precise perspective by arguing that the right of the patient is so clear that no court action is required, necessary, or, indeed, appropriate.

Second, by refusing to rule, Judge Gage avoided ordering any specific physician or health care facility to carry out Rivlin's wishes. In a case with fewer options, refusal to rule might have had an unfortunate impact on the patient's ability to exercise his own rights. In the Rivlin case, however, the patient's wishes were carried out without forcing any physician or facility to engage in behavior contradicting their own positions or compromising their moral integrity.

The Committee rejects the notion that physicians in Michigan ought not to withdraw life-sustaining treatment without a prior guarantee of legal immunity. In daily practice, we physicians do not seek court orders endorsing routine management such as treating strep throat or performing Pap smears. We simply believe that standards of good medical care, as well as the law, hold these actions to be fully permissible so that any risk of legal liability is so remote as to be inconsequential.

Judge Gage's "non-ruling" invites Michigan physicians to view the acceptance or refusal of life-sustaining treatment by a competent patient in the same light as more mundane medical management. And national custom and legal record bear out that no significant liability attaches to this action.

It is, however, one thing to possess a right, and quite another to exercise it wisely or prudently in particular circumstances. Despite acknowledgement that Rivlin was fully rational and aware of the implications of discontinuing ventilation, and had the right to do so, the tragic nature of his decision was heightened by his considerable wit and intelligence. Faced with the momentous nature of such a decision, a physician attending a patient like Rivlin might well be obligated to go to great length to try to persuade the patient to change his mind. Ideally, however, this persuasion always would respect the patient's ultimate right to choose his own fate.

Guidelines in the works

In cases like this, it may be difficult for physicians to be sure they have accurately assessed the patient's capacity to make a rational decision. Rather than using "competence," a legal term, physicians should address themselves to clinically assessing the patient's "capacity to choose." The MSMS Committee on Bioethics is currently drafting guidelines which may help Michigan physicians with difficult decisions of determining capacity to choose.

Doctor Brody is chairman of the MSMS Committee on Bioethics. Doctor Bryant is MSMS immediate past president.

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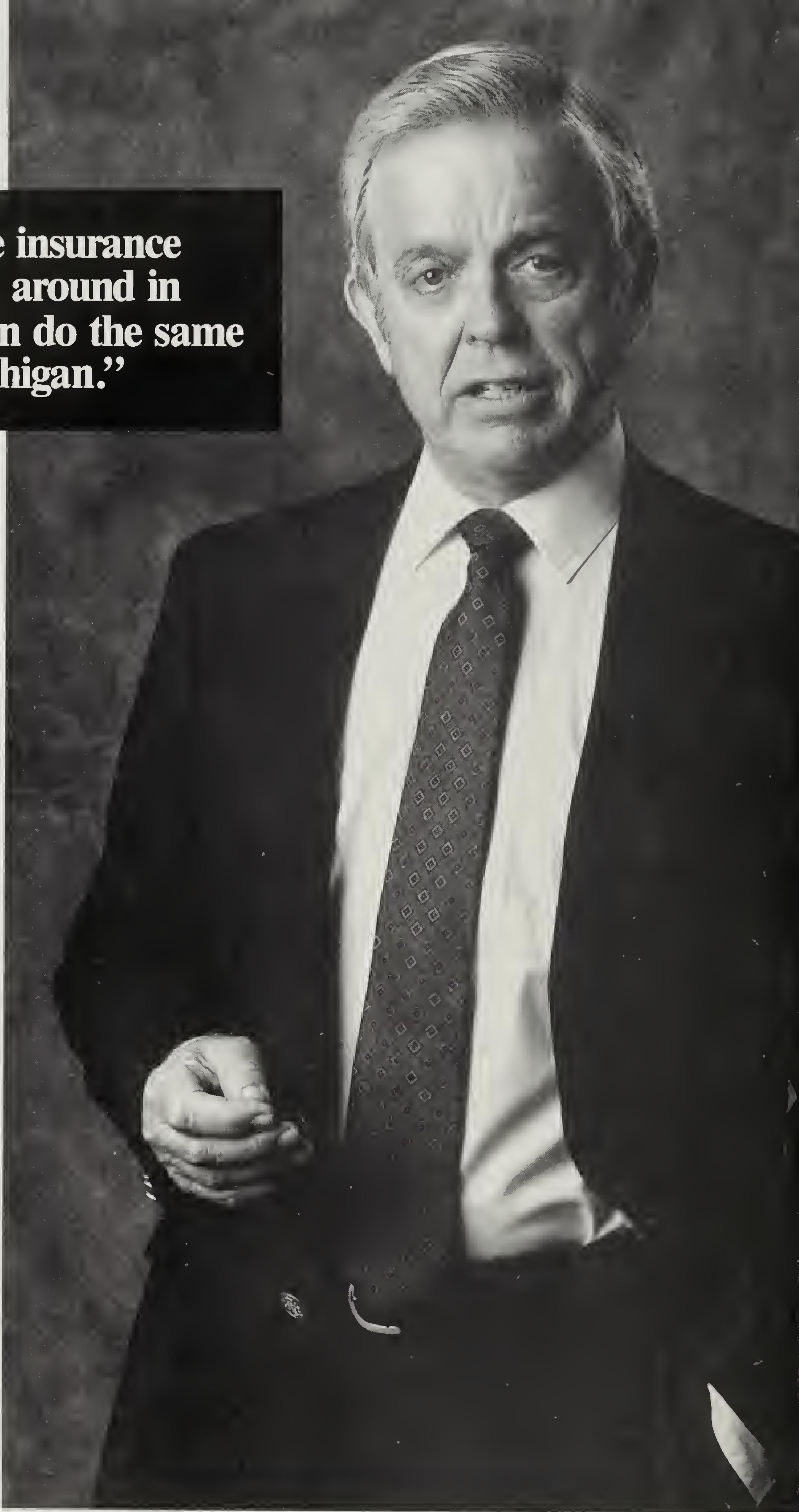

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PUBLIC AFFAIRS LEADERSHIP CONFERENCE

Highlights

The MSMS 1989 Public Affairs Leadership Conference, held September 26 in Lansing, offered Michigan physicians a full day of enlightening discussions — all of which were designed to help physicians "Focus" on important health care issues. Perhaps the most popular session of the day was "The Canadian Health Care System," which featured John O'Brien-Bell, MD, president of the Canadian Medical Association. Also popular was the panel discussion on "Universal Health Care," which featured Doctor O'Brien-Bell; David C. Hollister, state representative, 58th District; and Gerald R. Faverman, PhD, chairman, Public Sector Consultants, Lansing. Photo highlights of these and other sessions begin on page 32.

Above: More than 125 people attended the 1989 MSMS Public Affairs/Leadership Conference September 26 at the Lansing Radisson Hotel. Topics at this day-long event ranged from a keynote presentation on "The Canadian Health Care System," to a stimulating discussion on "Positively Medicine."

Right: MSMS President Robert E. Paxton, MD, told physicians attending the session on "Medical Volunteers": "While liability is a definite concern, we need to show communities what we can do. We must correct the public image of physicians."

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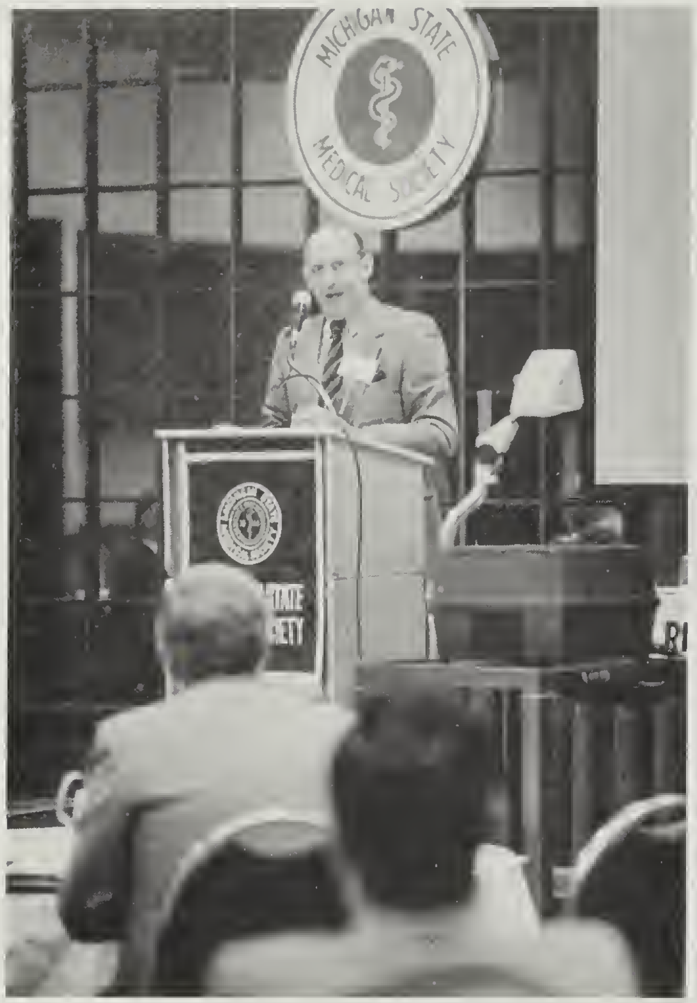

Left: John O'Brien-Bell, MD, president of the Canadian Medical Association, told physicians in his keynote speech that the Canadian government must now deal with a public which has "unlimited expectations and no understanding of cost." The Canadian health care system is at a watershed, he declared. "If we don't get over it, we will start to see a second tier (of private care) emerge. The public will demand it."

Above: Mitchell A. Rinek, MD, chairman of the 1989 Public Affairs Leadership Conference, welcomed attendees to the day-long event, which began with a presentation by Canadian Medical Association President John O'Brien-Bell, MD, and ended with a tour of the State Capitol Building, a government affairs briefing and a legislative reception.

Left: "The media and the general public are tired of hearing about the malpractice crisis. They want to hear about what we are doing for the communities," Scott Ferris, MD, Farmington Hills, told physicians in his presentation on "Medical Volunteers." Doctor Ferris, who travelled to Mexico to aid earthquake victims in 1985, said physicians should volunteer their services at least one hour a week.

Left: MSMS President-Elect Susan H. Adelman, MD, moderated the panel discussion on "Universal Health Care." The session immediately followed the presentation by Doctor O'Brien-Bell.

Above: David C. Hollister, Democratic state representative from Lansing, told physicians during the panel discussion on universal health care that we have "two-thirds of a consensus" on a national system. "The debate is on what kind and how to finance it." He said the polls show the public would support an increase in the income tax, if the increase were earmarked for health care. "If we can get to that debate, we will have national health service in five years."

ADELMAN
O'BRIEN - BELL
HOLLISTER
FAVERMAN

Above: Canada and the United States received equal attention in the panel discussion on universal health care. Panelists included (from left to right): Doctor O'Brien-Bell, Rep. Hollister, and Gerald Faverman, PhD, president of Public Sector Consultants, Lansing. Seated next to Faverman is Mitchell A. Rinek, MD, conference chairman.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Board of Medicine Actions

The Following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

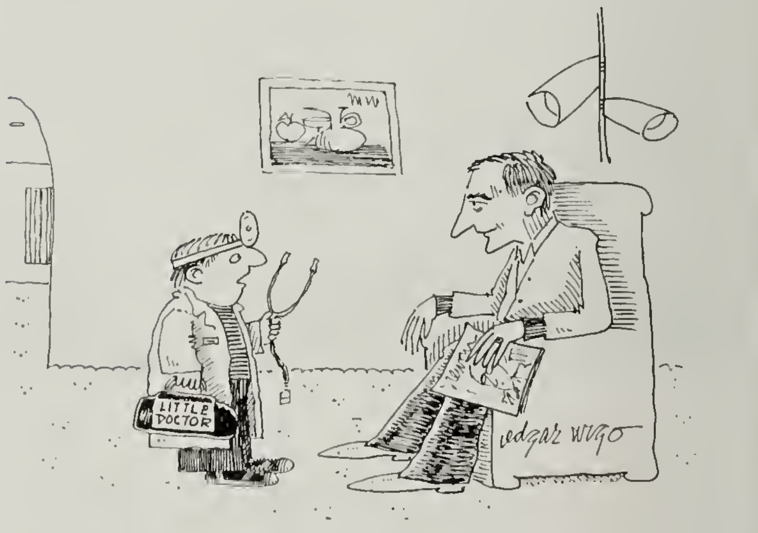
Name: Robert L. Alexander, MD, 345 Highland Court, Plainwell, MI 49080
Action, Date Taken: Voluntary Surrender Pending Final Disposition; July 10, 1989
Reason: Interim Action by Stipulation

Name: James E. Gotham, MD, 20205 Vernier #3, Harper Woods, MI 48225
Action, Date Taken: Revoked; Fined $1,000; September 20, 1989
Reason: Practice Outside the Scope of License

Name: Stephen D. Hershey, MD, 200 Riverfront #14 EH, Detroit, MI 48226
Action, Date Taken: Suspended 10 months; September 20, 1989
Reason: Substance Abuse

Name: Lloyd Livingston Miller, MD, P. O. Box 293, Southfield, MI 48037
Action, Date Taken: Revoked; October 6, 1989
Reason: Criminal Conviction — Drug Related

Name: George C. Ramsay, MD, R#4, Box 412, Gadsden, AL 35901
Action, Date Taken: Suspended one year; Fined $500; October 20, 1989
Reason: Drug Related



"DAD, I NEED TO TALK WITH YOU ABOUT MY INVESTMENT PORTFOLIO."

MSMS

Offers Members New Health Insurance Benefits Effective March 1, 1990

By Peter Marabell

MSMS Group Health Insurance Plan service representatives meet weekly to discuss customer inquiries and insurance issues. Pictured left to right are: Kathy Hagen; Jane Walworth; Barbara Zimmerman, MSMS Group Health Insurance Plan coordinator; and Cari Ambrose.

"Cut the telephone line! Disconnect the doorbell! Uncle Harry's selling insurance!" Those were the good 'ole days when the Uncle Harrys of the world banged on our doors until we bought whatever they were hawking. But were the old days *really* that good, or does it just seem that way?

"Insurance coverage never was that simple, and it has changed dramatically over the last 30 years," says Robert E. Paxton, MD, MSMS president and Group Insurance trustee.

MSMS Group Insurance trustees work on behalf of members. Trustees include B. David Wilson, MD, Jack Barry, MD, Billy Ben Baumann, MD, Henry M. Domzalski, MD, and William E. Madigan, MSMS executive director. The primary purpose of the trustees is to respond to the needs and complaints of physicians in order to find the best insurance coverage at the best price.

"Surprisingly, some MSMS members think that we, the trustees, are agents for Blue Cross Blue Shield," notes Doctor Baumann. "We're not! We certainly are well informed, but we're not agents for any particular insurance company, and we don't want to be. What we do is work for the physicians. We listen and respond to what they say."

As of March 1, 1990, a new range of options will be offered to physicians and employees (assistants) for their BCBSM health insurance, thanks to the efforts of the trustees. Each of the two plans, one for physicians, one for employees (assistants), has three basic choices: a "First Dollar" hospital-medical-surgical option and two comprehensive options, each with a different deductible.

Changes in specific riders also will affect the cost of premiums beginning March 1. Such is the case with the adoption of a family continuation rider. An FC rider, as it is often called, provides that dependents aged 19-25 will continue to be covered, but the cost of coverage will be borne by the individuals with those dependents. "It'll save most of our members money every month," says Doctor Wilson. "The new provision benefits more people than the old one." In fact, better than 60 percent of those covered will save money under the new arrangement.

"We've built the new specialized options around the Blues' plan," states Madigan. "I'm convinced the new options will bring more MSMS members, particularly younger physicians, to our insurance program." The more members who participate, of course, the lower the premiums.

"But let's be honest about one thing," cautions Doctor Wilson. "If two people sign up today, rates won't drop tomorrow. On the other hand, we've been signing 100 new contracts a month. So, if two new people sign a contract with us today and every day, which is a lot of new contracts, then the cost of premiums will go down."

A need for new options

Costly premiums have been a great concern for many MSMS members in recent months, according to Michael Kelly, marketing coordinator for insurance, Physician Service Group Inc. (Physician Service Group, Inc., is an MSMS subsidiary which offers a wide variety of services including insurance.) "Member response to our benefit plan has been mediocre at best," he says.

To learn more about member concerns, MSMS Group Insurance trustees decided to conduct a survey with the help of consultant Martin Block, PhD, of Evanston, Illinois.

Block sent questionnaires to all 11,952 MSMS members, and nearly half of them were completed and returned. The survey produced a fascinating picture of the membership in addition to information for the trustees. Block learned that MSMS members are "widely distributed across the state (in) a variety of settings and medical practices." More specifically, 39 percent of the physicians operate a single practice, 35.8 percent work in a specialty group, the remainder in a mixed bag of

Continued on page 36

Continued from previous page

settings including HMOs, academic hospital-based and administrative positions. One-third of MSMS members live and work predominantly in Greater Detroit. Most physician members (80 percent) are male. They are fairly evenly distributed in age groups of 39 and under, 40 to 49, 50 to 59, and 60 and over, with a slight bulge in the 40-49 aged group. Most are married, with children. Internal medicine and family practice are the largest specialties, in terms of numbers, with 15.3 percent and 12.8 percent respectively, of members responding.

Using this information as a base, Block asked some specific questions about dissatisfaction with services. The Block report clearly indicated that member discontentment was based on the cost of coverage. Forty percent of MSMS members elected to go with the Blue Cross/Blue Shield plan, but they were not as satisfied as the trustees had hoped. "It was a tough lesson to learn," Doctor Barry admits, "but we can't satisfy our members unless we know why they're unhappy."

The Block survey also pinpointed what members want in the future. It's not surprising that most members are particularly concerned about catastrophic health care as well as regular health insurance. The report confirmed that older physicians in single practice use MSMS services more frequently. That is important for the trustees to know. "We also learned that younger physicians under 40 were not using our services as often, but they are the group most interested in future services," Doctor Baumann says. "That meant our benefit plan had to change. We had to revise our insurance options, so they would be more appealing and affordable for younger physicians."

"That's just what we've done with the new options that go into effect on March 1, 1990," says MSMS Executive Director William E. Madigan.

Comments Doctor Paxton: "I'd like to explain something important, and it needs to be understood because it's a hard lesson to hear. What it comes down to is that quality coverage does not come cheap. . .not today. . .not any more. We have to face that reality, whether we like it or not. Twenty years ago, people signed up for insurance and that was that. Well, it's not that simple any longer. I want our physicians to think about our new options that will go into effect March 1."

More research conducted

To help find out if a new package of options based on a Blue Cross/Blue Shield plan would satisfy members needs, the trustees turned to Health Decisions, Inc., Livonia, Michigan, for some answers. HDI's goal was to gather information about coverage, particularly controlling costs.

After an extensive survey, HDI's recommendation was to stay with a package of Blue Cross/Blue Shield options. HDI offered hard evidence that the Blues were the best choice. A notable complaint from members involved late renewal notices, which left little time for thoughtful consideration. "That will end," Madigan says emphatically. "We're also going to make sure that all our procedures are clear and understandable."

The survey also indicated that most members prefer talking with MSMS service consultants rather than calling the Blues. "I was happy to hear that," Doctor Barry says, "because we want our members to get personalized attention." When members call the Blues for information or help with a problem, they talk to a new person each time. They end-up retelling the entire story. "When members call Kathy Hagen, Jane Walworth, or Cari Ambrose in our office, they can talk with whichever one is familiar with their situation," he adds.

For an information packet on the new insurance options, MSMS members are encouraged to call Group Insurance service representatives Kathy, Jane, or Cari at (800) 942-4141. ■

Peter Marabell, a Michigan State University professor, is a freelance writer and is general manager of GPM Communications, East Lansing.

Individual Program Options for MEMBERS

Effective March 1, 1990

Option I

Comprehensive Hospital/Medical/ Surgical with Master Medical Hospital/Medical/Surgical

No copayment when the services are provided by a participating hospital or health care professional.

Master Medical

Deductible: $150 per person, per calendar year, $300 per family limit

Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

■ BCBSM Complementary "Exact Fill" for Medicare beneficiaries

■ Family Continuation Rider (additional charge per 19-25 year-old dependent)

■ Sponsored Dependent Rider (additional charge per dependent age 25 to 65)

Option II

Comprehensive Major Medical (CMM 500)

Deductible: $500 per person, per calendar year, $1000 per family limit

Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

■ BCBSM Medicare Complementary coverage not available

■ Family Continuation Rider (additional charge per 19-25 year-old dependent)

■ Sponsored Dependent Rider not available

Option III

Comprehensive Major Medical (CMM 1500)

Deductible: $1,500 per person, per calendar year, $3,000 per family limit

Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

■ BCBSM Medicare Complementary coverage not available

■ Family Continuation Rider (additional charge per 19-25 year-old dependent)

■ Sponsored Dependent Rider not available

Beginning March 1, 1990, a $5 Copay Prescription Drug Program will be available as an option for you to select on all MSMS health insurance benefits at an additional premium.

This is intended to be a brief description of benefit programs beginning 3/1/90. For details, call (800) 942-4141.

Individual Program Options for EMPLOYEES

Effective March 1, 1990

Option I

Comprehensive Hospital/Medical/Surgical with Master Medical and PREVENT

Hospital/Medical/Surgical

No copayment when the services are provided by a participating hospital or health care professional.

Master Medical

Deductible: $150 per person, per calendar year, $300 per family limit

Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

- BCBSM Complementary with Master Medical 65 for Medicare beneficiaries
- Family Continuation Rider (additional charge per 19-25 year-old dependent)
- Sponsored Dependent Rider (additional charge per dependent age 25 to 65)
- Maternity waiting period: 270 days Pre-existing condition: 180 days

Option II

Comprehensive Major Medical (CMM 250) and PREVENT

Deductible: $250 per person, per calendar year, $500 per family limit

Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

- BCBSM Medicare Complementary coverage not available
- Family Continuation Rider (additional charge per 19-25 year-old dependent)
- Sponsored Dependent Rider not available
- Maternity waiting period: 270 days Pre-existing condition: 180 days

Option III

Comprehensive Major Medical (CMM 1000) and PREVENT

Deductible: $1,000 per person, per calendar year, $2,000 per family limit

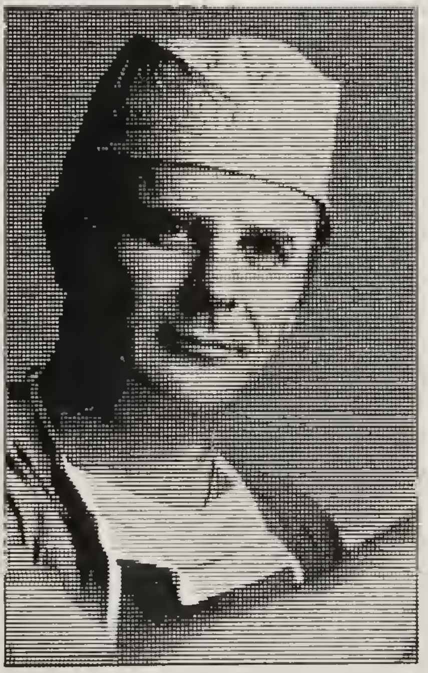
Copayments: 20 percent — general services 50 percent — mental health care and private duty nursing

Annual copayment maximum of $1,000 (excludes mental health and private duty nursing)

- BCBSM Medicare Complementary coverage not available
- Family Continuation Rider (additional charge per 19-25 year-old dependent)
- Sponsored Dependent Rider not available
- Maternity waiting period: 270 Pre-existing condition: 180 days

Beginning March 1, 1990, a $5 Copay Prescription Drug Program will be available as an option for you to select on ***all MSMS*** *health insurance benefits at an additional premium.*

This is intended to be a brief description of benefit programs beginning 3/1/90. For details, call (800) 942-4141.



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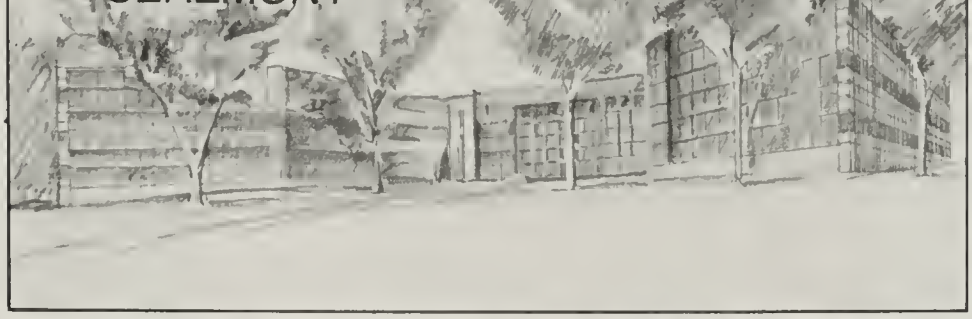


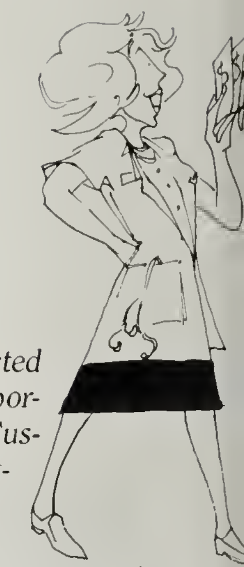
Above: Hagadorn, Inc., the MSMS/Michigan Physicians Mutual Liability Company (MPMLC) joint venture corporation, broke ground September 20 for a new East Lansing headquarters for the insurance company. Tossing shovels of dirt were MSMS President Robert E. Paxton, MD (right); Hagadorn, Inc. President Leland E. Holly, MD, (center); and MPMLC President Thomas R. Berglund, MD.

Above: The three-story, 88,000 square foot structure will give MPMLC plenty of room for expansion, said Doctor Berglund (at the podium). MPMLC will occupy two-thirds of the new building; the remainder will be open for lease.

Left: Hagadorn, Inc., is a natural," said Doctor Paxton at the groundbreaking ceremony. "It gives MSMS, in its current headquarters, and MPMLC, in its new building, expansion room, and allows us to improve our services."

WHO WOULD SAY SOMETHING NICE
ABOUT A BILL COLLECTOR?...

... Over 1,100 professional and trade associations, including the Michigan State Medical Society.



MSMS continues its endorsement of I.C. System, Inc., which has recovered over $16,588,000 in past due accounts for members. MSMS members from Adrian to Alpena to Ypsilanti and Zeeland have used I.C. System to make major additions to their bottom line!

A member in Port Huron has recovered over $231,000 while another in Hastings has been able to deposit an extra $153,000 with the help of I.C. The company has recovered $141,300 for a member in Monroe, $140,000 for a member in Southfield and over $120,000 each for members in Pontiac, St. Joseph and Southfield. The returns are rewarding; however, I.C. System's services go beyond collections.

Although I.C. System is a nationally-recognized company, personalized service is provided locally by a full complement of locally-based field representatives working under the direction of Regional Manager Dal Ferris in Jackson. I.C.'s field staff covers the entire state of Michigan and takes a personal interest in members collection effectiveness.

I.C. also fulfills a membership education role by distributing regular publications which address a variety of good credit practices such as what to do about a bad check, how to find people who "disappear," effective internal credit policies, and the most advantageous credit collection calendar.

Members using I.C. System lock in assured returns with the company's guarantee to recover at least 10 times the initial cost of this service. Commissions are only 29 percent (not the usual 50 percent) of accounts actually collected over $50. Another important feature is I.C.'s Customer Service Department, available via a toll-free line, for answers to questions about accounts, resolution of problems or advice on credit practices.

Nationally, I.C. System recovered nearly $85 million last year for members of over 1,150 endorsing associations. In 1988 the company celebrated 50 years since its founding as an organization dedicated to providing service to associations and their members.

The value of your receivables is directly related to their age. For more information, contact John Richards, general manager, MSMS Subsidiary Operations, at (517) 337-1351.

Help Wanted

We are looking for spouses of Michigan physicians to join a progressive, dynamic, unique group--the Michigan State Medical Society Auxiliary.

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Send your dues today to your county Auxiliary treasurer. In return you will become one of the most informed persons about Michigan medical issues.

Incentive: A free state membership for any new member who becomes a unified county, state and national member.

For further information on the MSMS Auxiliary, contact Vi Heins at 517/337-1351.

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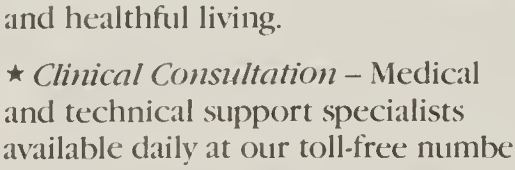

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Maria C. Abeleda, MD — P
21465 Green Hill Road #172
Farmington Hills 48020

Mostafa I. Abuzeid, MD — A
Two Hurley Plaza
Flint 48503

Andrew M. Aldridge, MD — P
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Detroit 48202

Gary M. Amundson, MD — R
3901 Beaubien Blvd.
Detroit 48201

Nina L. Anderson, MD — P
1292 Milverton Drive
Troy 48083

Kwabena Appiah, MD — OBG
29200 Schoolcraft
Livonia 48150

Kenneth S. Armstrong, MD — PTH
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Grosse Pointe 48230

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Farmington Hills 48018

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Grand Rapids 49503

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2021 Sundew
Troy 48098

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Detroit 48207

Alex Blaivas, MD — P
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Ann Arbor 48104

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Detroit 48201

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Sterling Heights 48078

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Southfield 48034

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Rochester 48309

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20905 Greenfield #700
Southfield 48075

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Kalamazoo 48001

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Grosse Ile 48138

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Detroit 48202

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Grosse Ile 48138

Susan B. Chamberlain, MD — PD
9960 Nancy's Blvd. #5
Grosse Ile 48138

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Lincoln Park 48146

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Ann Arbor 48109

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Dearborn Heights 48127

Continued on page 44

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Continued from previous page

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Muskegon 49442

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St. Clair Shores 48081

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Livonia 48150

Mark L. McDermott, MD — OPH
3994 John R
Detroit 48201

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2718 Peterboro
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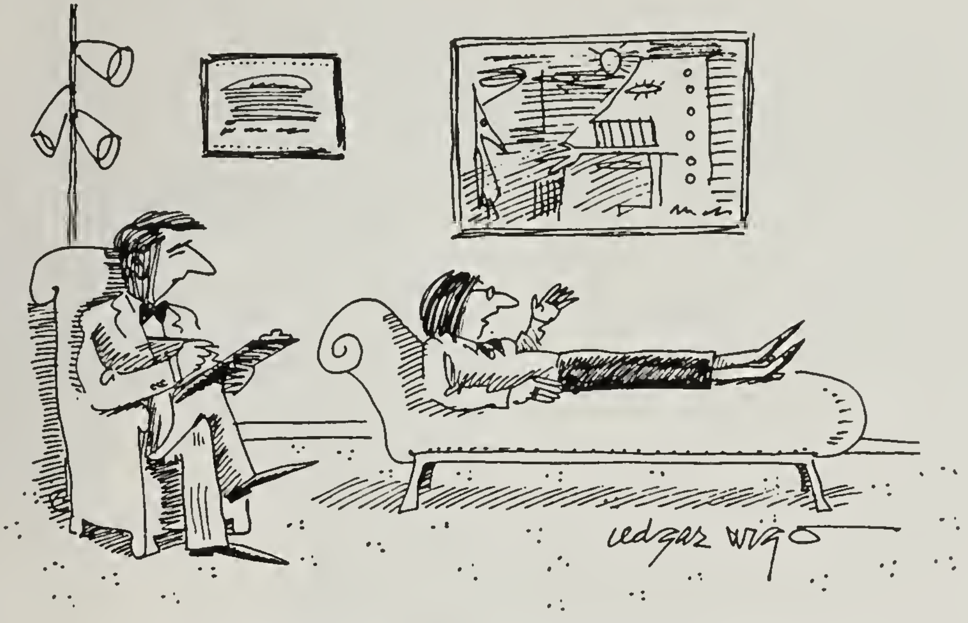

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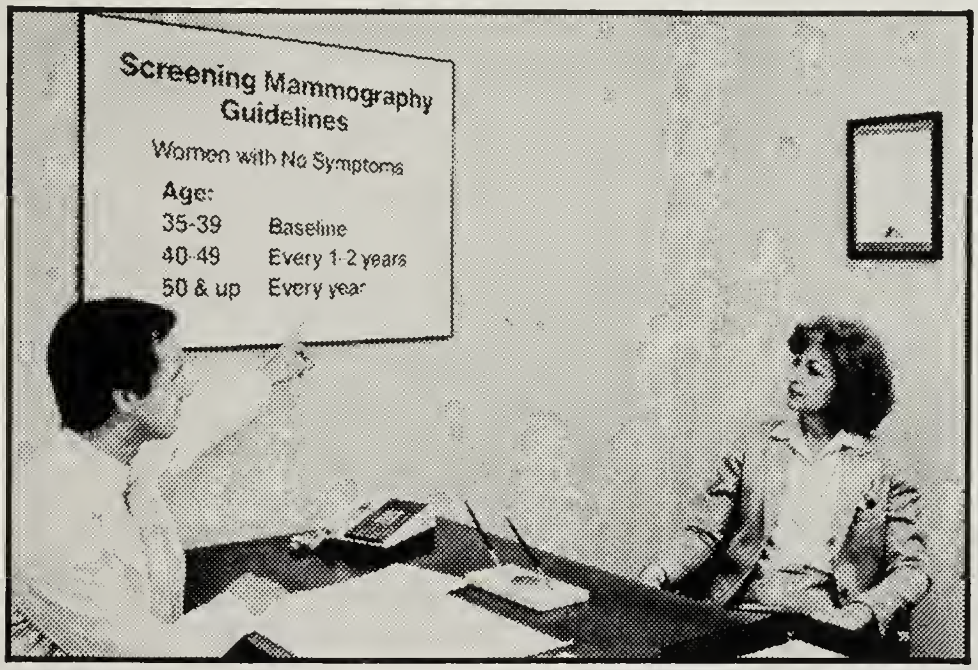

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Michigan State Medical Society

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Judith E. Marr, PO Box 950, East Lansing, Michigan 48826-0950

MANAGING EDITOR *(Name and Complete Mailing Address)*

Betty J. McNerney, PO Box 950, East Lansing, Michigan 48826-0950

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Judith E. Marr, Editor

DEATHS

James W. Hall, MD
Traverse City

James W. Hall, MD, an internist, died October 4. He was 78. Doctor Hall graduated from high school at the age of 16 and received his medical degree from the University of Chicago when he was 24. He served as a physician and first lieutenant in the US Army Medical Corps from 1940-1945 and then moved to Traverse City to become the first board certified internist to establish a private practice there. Doctor Hall was a former chief of staff at Munson Medical Center, president of the Tri-County Medical Society, and founder/first president of the Michigan Society of Internal Medicine. He was an active member of the American Medical Association, Michigan State Medical Society, and the American College of Physicians.

J. D. Miller, MD
Grand Rapids

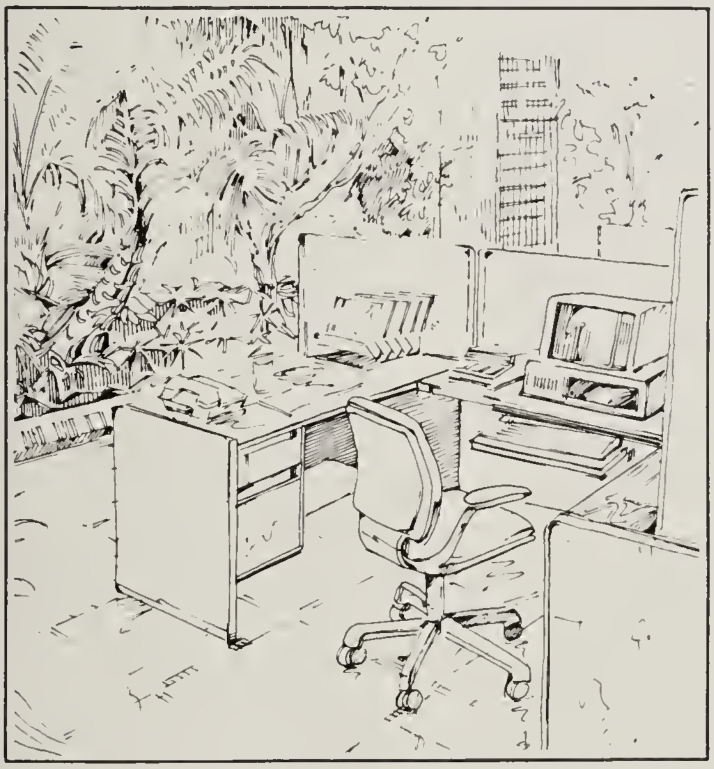
J.D. Miller, MD, a general surgeon, died September 29. He was 90. Doctor Miller received his medical education from the University of Michigan and served his internship at Blodgett Memorial Medical Center. He later enrolled at the University of Vienna for postgraduate training in pathology. In 1959, Doctor Miller assisted in the founding of the area's first health planning group, the Kent County Health Council. He retired from active surgery at the age of 79. He served as president of the Kent County Medical Society in 1952 and was a councilor in the Michigan State Medical Society from 1946 to 1957. Doctor Miller also was an active member of the American Occupational Medicine, the International College of Surgeons, the American College of Surgeons, and the Chicago Surgical Society.

Joseph Vincent Moleski, MD
Grand Rapids

Joseph Vincent Moleski, MD, a general practitioner, died October 2. He was 74. A 1942 graduate of Loyola Medical School, Doctor Moleski served as a Major in the Jungle Air Force in WWII. He practiced medicine in the Grand Rapids area as a general practitioner specializing in obstetrics. Before his retirement in 1982 he had delivered over 4,500 babies.

Galen B. Ohmart, MD
Alpena

Galen B. Ohmart, MD, retired general surgeon, died October 1. He was 93. Doctor Ohmart served in the US Navy during WWI. He graduated from the University of Michigan Medical School in 1925 and opened his surgical practice in Detroit in 1931. Doctor Ohmart was on staff at Jennings Hospital in Detroit and became chief of staff at Bon Secours Hospital in Grosse Pointe. He retired in 1961 and moved to Alpena. Doctor Ohmart was a member of the American College of Surgeons and Michigan State Medical Society for more than 50 years.



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MEETINGS

MSMS Meetings

January

17, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

February

7,8, MSMS/PSG, How to Run a More Profitable Practice. 7th - Dearborn Inn, Dearborn, Michigan. 8th - Amway Grand, Grand Rapids, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

14, MSMS/PSG, Financial Planning, Hyatt Regency, Dearborn, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

15, MSMS/PSG, Stress Management, Somerset Inn, Troy, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

21,22, MSMS/PSG, Medical Collections. 21st - Amway Grand, Grand Rapids, Michigan. 22nd - Hyatt Regency, Dearborn, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

March

6,7,8, MSMS/PSG, Third Party Reimbursement. 6th - University Club, East Lansing. 7th - Bay Valley Inn, Bay City. 8th - Grand Traverse Resort, Traverse City. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

14, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

20,21,22, MSMS/PSG, ICD-9-CM Diagnostic Coding. 20th - Amway Grand, Grand Rapids. 21st- Fetzer Center, Kalamazoo. 22nd - Hyatt Regency, Dearborn. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

21,22, Annual Conference on Maternal and Perinatal Health: "Perinatal Care: Access, Answers, Accountability," Hyatt Regency Dearborn. Contact: Sherry L. Fent, Chief of Physician Education, (517) 337-1351.

22,23, MSMS/PSG, Supervising and Managing People. Dearborn Inn, Dearborn, Michigan. Contact: Amy Fistler, (517) 337-1351 Ext. 65.

Michigan Specialty Society Meetings

January

13, Michigan Psychoanalytic Society Conference. "The Mental Representation of the Clitoris," Southfield, MI. Contact: Shirley Seffinger or Colleen Jaeger, 16310 W. Twelve Mile Rd., Suite 204, Southfield, MI 48076. (313) 557-8633 or (313) 559-5855.

21, Michigan Psychoanalytic Society Conference. "Normal and Pathological Mourning: Clinical and Theoretical Perspectives," Farmington Hills, MI. Contact: Shirley Seffinger or Colleen Jaeger, 16310 W. Twelve Mile Rd., Suite 204, Southfield, MI 48076. (313) 557-8633 or (313) 559-5855.

National Specialty Society Meetings

December

13-15, American College of Obstetricians and Gynecologists-Operative Gynecologic Endoscopy, New York, NY. Contact: ACOG Registrar, (800) 673-8444.

15-17, American Academy of Pediatrics, Williamsburg, VA, Contact: CME Registration, Department of Education, American Academy of Pediatrics, P. O. Box 927, Elk Grove Village, IL 60009-0927. Toll-free 800-433-9016 ext. 7657.

January

4-7, American Academy of Pediatrics, Vail Colorado, Contact: CME Registration, Department of Education, American Academy of Pediatrics, P. O. Box 927, Elk Grove Village, IL 60009-0927. Toll-free 800-433-9016 ext. 7657.

18-20, American College of Obstetricians and Gynecologists-Liability in Perinatal Medicine: Prevention and Defense, Carlsbad, CA. Contact: ACOG Registrar, (800) 673-8444.

22-24, American College of Obstetricians and Gynecologists-Detecting and Managing Fetal Abnormalities: Genetics and Ultrasonography, St. Thomas, VI. Contact: ACOG Registrar, (800) 673-8444.

25-27, American College of Obstetricians and Gynecologists/Case Discussions in Reproductive, Endocrinology and Infertility, St. Thomas, VI. Contact: ACOG Registrar, (800) 673-8444.

February

1-3, American College of Obstetricians and Gynecologists-Intrapartum Fetal Evaluation, Snowbird, UT. Contact: ACOG Registrar, (800) 673-8444.

16-18, American Academy of Pediatrics, San Francisco, CA, Contact: CME Registration, Department of Education, American Academy of Pediatrics, P. O. Box 927, Elk Grove Village, IL 60009-0927. Toll-free 800-433-9016, ext. 7657.

22-24, American Academy of Family Physicians Conference. New Orleans AIDS Conference: Management of HIV Disease for the Primary Care Physician, New Orleans, LA. Contact: Dr. Sandra Mahkorn, (504) 362-9355 or Mr. Bart Reilly, (504) 568-3855.

March

1-3, American College of Obstetricians and Gynecologists/Advanced Colposcopy, Las Vegas, NV. Contact: ACOG Registrar, (800) 673-8444.

15-17, American College of Obstetricians and Gynecologists/Common Problems in Obstetrics and Gynecology, New York, NY. Contact: ACOG Registrar, (800) 673-8444.

29-31, American College of Obstetricians and Gynecologists-Urogynecology, New Orleans, LA. Contact: ACOG Registrar, (800) 673-8444.

May

27-31, American College of Emergency Physicians, 19th Annual Scientific Assembly, Napa, CA. Contact: CAL/ACEP, (213)374-4039 or 800-SEK-ACEP.

Other Meetings

February

2-4, MSMA Mid-Winter Seminar: Roaring into the 90s. Contact: Yvonne Jones, CMA, 2864 Foster, Ann Arbor, MI 48104.

11-16, Fifteenth Annual Seminar on Emergencies In Medicine. Contact: Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201. (313) 745-3484.

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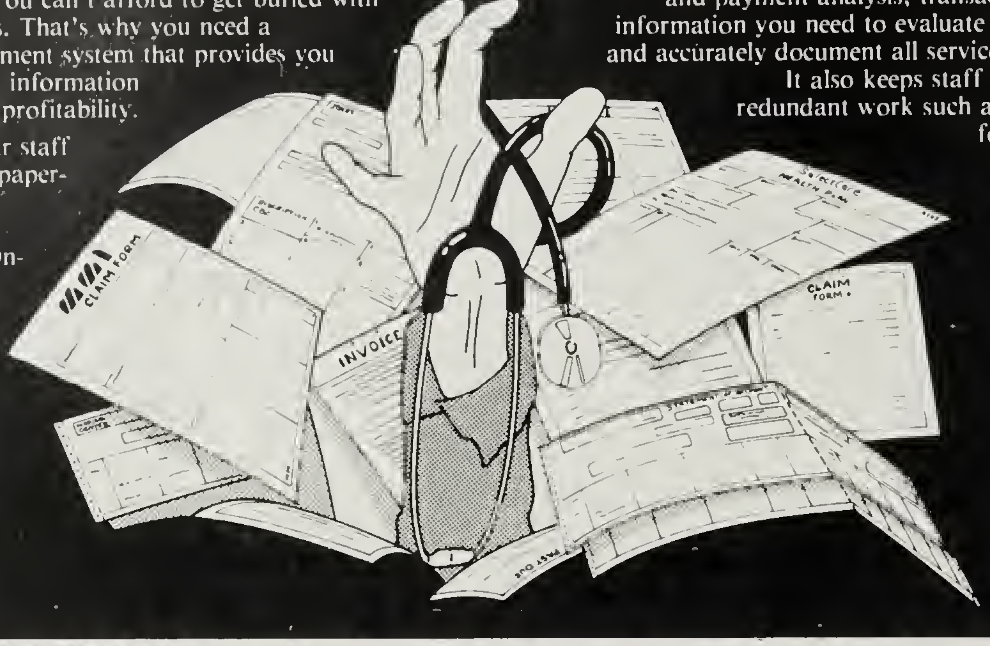

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CATEGORY I COURSES

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January 1990

26, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

27-28, Advanced Cardiac Life Support Provider Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313)7631400. **Approved for:** 16 hours Category I Credit.

28/2-2, 14th Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 20 hours Category I Credit.

February

23, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

23-25, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 21 hours Category I Credit.

24, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, G- 1100 Towsley Center-Box 0201, University of Continuing Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

March

5-6, Epilepsy Advances. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Continuing Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

9-11, The 10th Annual Advances in the Management of Infectious Diseases: Update. Location: South Seas Plantation, Captiva Island, FL. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 12 hours Category I Credit.

17-24, Facial Cutaneous Surgery: Mohs, Reconstructive, Cosmetic. Location: Copper Mountain Resort, Copper Mountain, CO. **Sponsor:** University of Michigan Medical School. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109- 0201. (313) 763-1400. **Approved for:** 30 hours Category I Credit.

20-24, Family Practice – 1990, Fourteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 35 hours Category I Credit.

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PRESIDENT'S PAGE

'Tis the Season for Self Evaluation

By Robert E. Paxton, MD

The holiday season is rapidly approaching and everyone tends to get into a festive mood. Our heritage of gift-giving generates within us the feeling of good will towards others.

I realize that medicine faces many problems today. We have discussed threats to our profession that come from all fronts. The politicians and bureaucrats are driven by a budget deficit to determine medical care by cost rather than quality. The public distrusts the profession, resorts to litigation that destroys the doctor/patient relationship, and blames us for the high cost of medical care.

Industry shirks its social responsibility and calls for universal health care with total regulation of doctors. Unfortunately, we even hurt ourselves as we must admit that inappropriate medical care and unreasonable charges occasionally do exist. Unity often falters and we become weakened by inter-specialty battles.

Develop a charitable attitude

In the midst of this disarray, Michigan physicians could find themselves discouraged, depressed or even angry. It is just at this crucial time that, surprisingly, I come pleading for a giving and charitable attitude. This type of attitude, I feel, is germane to our survival and to the preservation of a pluralistic health care delivery system in America — a system which is coupled with increased and adequate access so that all can enjoy its benefits.

I sincerely feel that most doctors enter medicine because they care for people and it provides a way to contribute to society's well-being. Our own MSMS constitution lists one major purpose for our existence: to organize the ethical physicians in Michigan in order that their contributions to human welfare will be enhanced.

Despite this, I have heard doctors grumble about altruistic endeavors when former AMA President Jim Davis challenged us to donate 10 percent of our time to charitable community involvement. It discourages me that some physicians refuse to be involved or contribute because they say they already are doing enough by accepting discounts when they care for Medicaid patients.

Evaluate priorities and goals

Let me tell you my concern. I have a problem when I meet with the press or with politicians and bureaucrats. Even though I have good arguments for our causes, I have no answers for them when they inquire about outlandish charges, questionable procedures or a perception that physicians no longer are motivated by humanitarianism. If we are to indeed regain the confidence of society and the respect we need to survive, then we must clean house and as individuals evaluate our priorities and goals in life.

I started this article by suggesting that this is the season for such evaluations. Think first of our concern for humanity and adequate material gain will follow. But you ask me, "What can I do?" "How can I contribute?"

First, check with your county medical society to see if it offers sponsor programs that involve community service. If none is available, encourage your county or state medical society to establish a local program and be instrumental in its formation. Your AMA delegate should have a copy of *Medical Societies Guide to Physician Volunteer Projects*, a booklet distributed by the American Medical Association. This lists several programs that have been instituted throughout the country which you might replicate in your area. I am chagrined to admit that none listed in the brochure were from Michigan.

Other alternatives include local programs sponsored by the Red Cross, the Salvation Army, your church or synagogue. A valuable suggestion is that you could financially support your own Health Education Foundation.

This brings me to what I've been leading up to in this article. I am disappointed that so few physicians even know what the Health Education Foundation (HEF) is or that they even have one! Worst yet, when we made an appeal to our membership over a year ago, the results were dismal.

HEF is the altruistic endeavor of the Michigan State Medical Society. Historically, it was founded to aid students with scholarship funding. Today it has evolved to its present state of health promotion, directed especially at the poor and underserved population of this state.

Please consider HEF when you make your charitable donations this season. Designate it as a recipient for memorials for loved ones and colleagues. This is a real and positive way that you can show your concern and MSMS can fulfill its purpose to help mankind.

You know that I strongly endorse unity of the profession for strength — grass roots involvement for effectiveness, political savvy for action, an aggressive agenda for realistic tactics. But underlying it all must be a strong and permanent foundation — a dedicated doctor/patient relationship that includes a caring, considerate and at times, even sacrificing physician.

Winston Churchill said, "We make a living by what we get, we make a life by what we give."

Merry Christmas and Happy Holidays! ■

Doctor Paxton is MSMS president.

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics. heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident

If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy In such patients, renal function should be monitored during the first few weeks of therapy

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic This is more likely to occur in patients with preexisting renal impairment Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials In most cases these were isolated values which resolved despite continued therapy Hyperkalemia was a cause of discontinuation of therapy in 0 28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC (See *Drug Interactions*.)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia Patients should be told to report promptly any indication of infection (e g , sore throat, fever) which may be a sign of neutropenia

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects

Drug Interactions:

Hypotension, Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and DOSAGE AND ADMINISTRATION)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC

Lithium. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose)

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters

There are no adequate and well-controlled studies of enalapril in pregnant women However, data are available that show enalapril crosses the human placenta Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity

Nursing Mothers Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate It is not known whether this drug is secreted in human milk Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother

Pediatric Use Safety and effectiveness in children have not been established

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were headache (5 2%), dizziness (4 3%), and fatigue (3%)

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were diarrhea (1 4%), nausea (1 4%), rash (1 4%), cough (1 3%), orthostatic effects (1.2%), and asthenia (1 1%)

HEART FAILURE The most frequent clinical adverse experiences in both controlled and uncontrolled trials were dizziness (79%), hypotension (6 7%), orthostatic effects (2 2%), syncope (2 2%), cough (2 2%), chest pain (2 1%), and diarrhea (2 1%)

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1 8%), headache (1.8%), abdominal pain (1 6%), asthenia (1 6%), orthostatic hypotension (1 6%), vertigo (1 6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1 3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1 3%), and myocardial infarction (1 2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0 5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category

Cardiovascular Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia

Urogenital Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION)

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection

Skin. Herpes zoster, pruritus, alopecia, flushing, photosensitivity

Other. Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur These symptoms have disappeared after discontinuation of therapy

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0 2%). Angioedema associated with laryngeal edema may be fatal If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS)

Hypotension: In the hypertensive patients, hypotension occurred in 0 9% and syncope occurred in 0 5% of patients following the initial dose or during extended therapy Hypotension or syncope was a cause for discontinuation of therapy in 0 1% of hypertensive patients In heart failure patients, hypotension occurred in 6 7% and syncope occurred in 2 2% of patients Hypotension or syncope was a cause for discontinuation of therapy in 1 9% of patients with heart failure. (See WARNINGS)

Clinical Laboratory Test Findings.

Serum Electrolytes Hyperkalemia (see PRECAUTIONS), hyponatremia

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1 2% of patients

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0 3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists In clinical trials, less than 0 1% of patients discontinued therapy due to anemia

Other (Causal Relationship Unknown) In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported

Liver Function Tests Elevations of liver enzymes and/or serum bilirubin have occurred

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed

If the diuretic cannot be discontinued, an initial dose of 2 5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day Dosage should be adjusted according to blood pressure response The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval In such patients, an increase in dosage or twice-daily administration should be considered If blood pressure is not controlled with VASOTEC alone, a diuretic may be added

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS)

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL) For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2 5 mg once daily The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis The recommended starting dose is 2 5 mg once or twice daily After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIONS, *Drug Interactions*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses The maximum daily dose is 40 mg Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2 5 to 40 mg per day of VASOTEC, almost always administered in two divided doses (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1 6 mg/dL, therapy should be initiated at 2 5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*) The dose may be increased to 2 5 mg b i.d , then 5 mg b i.d and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function The maximum daily dose is 40 mg

For more detailed information, consult your MSD Representative or see Prescribing Information Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486

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